The Psychosocial Risk Factors of Developing Perinatal Mental Health Issues in Birth Mothers of Compulsory Adopted Children

Puja Chandegra

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Abstract

Perinatal mental health (PMH) issues are a common public health concern effecting 10-20% of women during pregnancy and up to one year after birth (Public Health England, 2017). Various biopsychosocial risk factors can increase the likelihood of developing PMH issues and therefore, it seems valuable to understand this in the context of birth mothers of compulsory adoptions. Birth parents facing, or who have faced compulsory removal are frequently exposed to many psychosocial challenges but often disregarded within published literature. With this in mind, this research aimed to investigate the psychosocial risk factors around developing PMH issues within birth mothers of compulsory removals. Through a post-adoption agency, eight birth mothers were initially screened for historical PMH issues using the Edinburgh Postnatal Depression Scale (EPDS)- Lifetime (Meltzer- Brody, Boschloo, Jones, Sullivan & Pennix, 2013). The scores helped to indicate the severity of historical signs and symptoms of PMH issues. The mean score for this group of birth mothers was 21.6, suggesting a high severity of PMH signs and symptoms. Five birth mothers then took part in semi-structured interviews which were transcribed and analysed using thematic analysis. Five main themes were generated through analysis; 'Patchy knowledge of PMH', 'A troubled life', 'PMH problems present', 'The agonising grief', 'Time to change: pregnant again'. The findings suggested that birth mothers are at higher risk of experiencing PMH issues due to significant psychosocial risk factors such as a lack of social and professional support, lack of partner support, domestic abuse, maternal age, and breastfeeding termination. Implications of this novel research includes ensuring that there is consistent and routine screening for PMH in birth mothers and multi-disciplinary working. Professionals should also be encouraged to build trusting relationships with birth mothers who are often subject to stigma and discrimination.

Contents

1.0 Background:

This thesis will aim to add to the existing literature focusing on the perinatal mental health (PMH) issues within marginalised women. More specifically, this thesis will focus on the psychosocial risk factors associated with PMH issues experienced by birth mothers of historical compulsorily removed children, an area which has previously not been researched. As an introductory chapter, this section will define and discuss PMH in the context of prevalence, severity and the impact it can have on a mother and her wider family. Information and statistics related to the number of compulsory removals of children within the UK, including adoptions, are also introduced within this chapter, in addition with the common determinants that result in compulsory removals.

Mental health can be defined as a state of wellbeing in which one realises their own potential and can cope with normal life stressors and can work productively to contribute to their community (WHO, 2020). Therefore, good mental health, in effect, is a positive or satisfactory state of psychological wellbeing and absence of a mental illness. An individual with poor mental health may be characterised by experiencing mental health problems, altered thinking and behaviours (Mind, 2020).

Within this research, the focus lies around PMH. PMH complications refer to a problem that may occur during pregnancy or up to a year after birth. Almost 1 in 10 women will experience PMH issues during this period. Despite the high prevalence of PMH, five years ago, access to specialist PMH services varied, and 40% of England had no specialist community teams to support women and families. This is now rapidly changing with all 44 local NHS areas having access to specialist community teams (NHS England, 2020). Despite this there are still barriers and challenges to overcome so that all women have a fair access to perinatal mental health services (Public Health England, 2017). Untreated or unattended PMH issues may worsen and have a significant impact on both mother and child, or even the wider family (NHS, 2016).

PMH complications can commonly present itself as pre or postnatal depression, pre or postnatal anxiety and pre or post psychosis, including OCD (O'Hare & Wisner, 2014). Within academia, research and studies around PMH issues have generally focused on the postpartum period and more commonly around postpartum depression and psychosis

which often assumes that in order to experience PMH, a child would be within the care of that parent (Howard & Khalifeh, 2020).

In more recent years research, campaigns and grass roots organisations have also demonstrated that PMH complications can also be experienced due to perinatal loss. This may include child bereavement or loss of any through pregnancy and immediately after birth can lead to complex grief and trauma and increase the likelihood PMH complications in subsequent pregnancies (Lamb, 2002). Still, it has been long acknowledged that care and support for families who have experienced perinatal loss is still inconsistent across the UK (Sands, 2020). However, research, campaigns and awareness around perinatal loss seem to be increasingly on the rise to raise awareness (Baby loss awareness week 2019; Sands charity 2020, Tommys, 2020, Lullaby trust, 2020, Bliss, 2020).

Based on the notion that PMH issues can be experienced by parents who may not physically have their children within their care, it can be assumed that this belief would also apply to birth mothers who have had their children removed by statutory services. This unwilling loss can also have the great potential for parents to experience complex grief, trauma, and PMH complications in future pregnancies. Certain blog sites have indicated support for birth mothers going through postpartum depression (Angel Adoption Blog, 2016). It is important to be aware of the impact PMH issues may have on biological or birth mothers of adopted child(ren). The term 'birth mother' refers to the biological mother of an adopted child.

According to the NSPCC (2020), 60% of children are in care due to severe neglect or abuse, followed by family dysfunction and parental mental health problems. Adults or parents with mental health problems, are more likely to abuse drugs and alcohol, with strong links around partner violence (Institute of Public Care, 2015). In an analysis of 175 serious case reviews around children, 53% of them indicated parental mental health problems as reasons for removal (Sidebotham, 2016). Serious case reviews are held after a child or adult dies or is seriously injured under circumstances where abuse or neglect are thought to be involved. The serious case reviews raises questions as to how many birth mothers of compulsory removals experienced PMH issues, alongside domestic violence and, or substance misuse. Understanding this can help practitioners to intervene with the right support, and potentially prevent removals. However, within adoption related research, much research has often only focused on the child or the adoptive parents. Despite the

long-term mental health and social consequences birth parents face, birth parents are often forgotten amongst literature and research (Logan, 1996), O'Leary- Wiley & Baden (2005) have pointed out that birth parents are often the least studied and understood within the adoption triad, and especially those who have faced compulsory removals due to lack of service trust and the stigma they face by society.

In the context of birth mothers of compulsorily removed children, they are potentially at a greater risk of developing more severe PMH issues due to myriad of problems they traditionally face and being coupled with a removal against their own will. It seems relevant to understand the experiences of compulsory removals from a birth mother's perspective whilst investigating whether their experiences may have impacted PMH problems. To date no literature has explored the historical experiences of compulsory removals faced by birth mothers, whilst exploring the psychosocial risk factors they may have experienced, and the impact on PMH complications. It seems important to examine the prevalence and experiences of such a common public health condition in a group of vulnerable mothers who are often unseen amongst adoption and social work literature.

I expand of my rationale and motivation to undertake this research more on page 57 within the reflexivity section.

With this being a novel piece of research, the next section will focus on a legal process around compulsory removals, and a literature review that will provide an overview of the following areas:

2.1 a summary of the child protection plan within the UK;

2.2 followed by a summary of the plan for adoption within the UK

3.0 a literature review surrounding the existing knowledge and research around birth mothers of compulsory removed children;

3.1a more specifically stigma and barriers birth mothers face

3.2 what perinatal mental health is and;

3.3 the signs and symptoms of PMH

The literature will also consider:

3.4a PMH in terms of the psychosocial and cultural factors that protect or increase the likelihood of developing PMH issues whilst linking it within the context of birth mothers;

3.4b and the biological or genetic considerations around the development of PMH issues.

The literature will further consider:

3.5 the impact on how PMH issues can influence a child's development, and more specifically how identifying risk factors early within birth mothers may prevent developmental harm on children.

2.0 Legal & Legislative Process within Child Protection & Adoption:

To begin with, this chapter will introduce the legislative and legalities around the child protection plan and adoption within the UK. These are legislative decisions by local authorities and courts within the UK.

2.1 Summary of the Child Protection Plan, UK: (Legislation. gov, 2020; & Department for Education, 2013)

Protecting a child or vulnerable people is often at the forefront of many organisations. When a child is at risk of ill-treatment or neglect there is an obligation by professionals, workers and public to safeguard the children by immediately following a safeguarding process which is often outlined by the place of work or practice. Public can also do this by contacting the police as soon as possible, or children's services through a local helpline.

Where risks to the child persist, the child protection plan (CPR) is a legal plan set out by the local authority which considers how a child is kept safe, and what things can be put in place for a family to support them. This section will provide an overview of the child protection plan within the UK. The CPR is an important document and planning phase to clearly set out the needs for the children.

The current child protection plan in the UK under section 22 of the Children Act (1989), means that the safeguarding and wellbeing of children is at the forefront of any decisions. The Children Act (1989) can be defined as a 'child in need; or at risk of 'significant harm'. Significant harm indicates "ill treatment or the impairment of health or development". Therefore, there is a high expectancy or importance placed on professionals working within children's services that the child's needs should come first. If there is a potential immediate concern over the child's welfare, the local authority (LA) will remove the child from home.

'Care proceedings' is the legal process by which the LA will request the court to take the child into care (NSPCC, 2014). During this process, if the LA is not happy in the way the child's needs are being met or cared for, a child protection plan will be devised in conjunction with the parents and other professionals to safeguard the child. Professionals will work with the family to assess whether the child can be returned home (NSPCC, 2014).

During care proceedings, if parents are unsuccessful at following the plan, a *legal planning meeting* will begin and the local authority will look at other potential family members who could care for the child. If there are still no significant improvements in birth parents parenting practices the parents will be required to attend meetings with a more rigid plan to determine how they will change to look after the child.

After around 3 months, if the social workers are still unsatisfied around how the child's needs are being met, the LA can apply for a placement order. The placement order will require extensive reports written by social workers and a court advisory support team, to the court, to determine the child's future. Parents may be required to go to court several times until the court has made a final decision about where the child should be placed i.e., long-term fostering, being placed with a family or friend, or adoption. The next section will discuss and outline the plan for adoption within the UK.

2.2 The Plan for Adoption: (Legislation. gov, 2020; & Department for Education, 2013)

A plan for adoption is ordered by the court when it is unsafe for a child to return home. This section provides an overview of the process around adoption from the viewpoint of a birth family who have faced a compulsory removal.

Where it is unsafe for the child to be returned home, the court will decide that the plan will be for the child to be adopted. Adoption is a legal process can be defined as removing any parental responsibility from the birth parents and transferring them to the adoptive parents.

The local authority will be obliged to ensure that the birth family receive independent support usually from an independent adoption agency to avoid any conflict of interest. The independent agency will offer support to the birth family during the whole process of adoption however cannot change any decisions made by the LA. During this period, an extensive search for adoptive parents who meet the child's needs are underway whilst the child is in foster placement. Birth parents and the LA will share parental responsibility at this stage. The independent agency will work with and support birth parents with various aspects such as emotional support, assistance with contact arrangements (i.e., meeting with their child once a week which will gradually decrease when adopters have been matched), encourage the birth parents to provide chronological, personal, and sentimental information for the child's life story book which they will be able to read when they are 18. Birth parents can also contribute to the child's permanence report (CPR).

A 'Child Permanence Report' is a requirement of the Adoption Agencies Regulations 2005. It is the document that is presented to an Adoption/Fostering panel to enable a decision to be made about whether it is in a child's best interests to be placed for adoption or with long term foster carers.

A section of the CPR highlights the birth family background including their own childhood. The information on this should be agreed by the birth parents. Therefore, it is important that they can view this to ensure information is factual and correct. If they do not wish to contribute, the social worker responsible for writing the CPR would have to go by any information they already know. This may be very limited.

The independent agency will also offer support on negotiating letterbox arrangements. This is usually set up when adopters have been identified. Letterbox contact usually takes place annually, with the adoptive family providing an update on the child's progress to the birth parents. The birth parents will then respond to this letter. The letters are exchanged via the LA that granted the adoption. When prospective adopters have been matched to the child, the birth parents have limited legal responsibility of the child.

The independent agency will support the birth parents to meet with the prospective adopters and will be encouraged to do so. At this point, the LA will have the authority reduce contact sessions to possibly once every few weeks, or monthly until the child is placed with the adopters. The independent agency would provide emotional and practical support for the final contact session.

For the child to be legally adopted, the child will have to live with the adopters for a minimum of 10 weeks. Following this, the adopters will apply for a court application to legally adopt the child. The birth parents will be notified of this court hearing and will give the birth parents an opportunity oppose the adoption order. If they choose to oppose the adoption order, this will delay the hearing and the child will remain in the adoptive placement longer. This in fact may go in favour for the child to be permanently adopted as they have settled into their new adoptive placement.

3.0 Literature Review

The literature review will be compromised of six sub sections which will help to draw together the rationale for this research, and in turn the research questions. The literature will also introduce research focusing on birth mothers and the stigma they face, followed broadly by what PHM issues are in terms of signs and symptoms, the risk factors associated with PMH issues, and how PMH issues can impact child development.

3.1 The Birth Mother: implications of compulsory removals

This section discusses the psychological and physical impact of compulsory removals on a birth mother. Birth mothers who both voluntarily give up their children, and who have them compulsorily removed are often faced with the reality of stigma and discrimination within society, and sub-section 3.3a of this chapter will consider more specifically on the literature around this.

Birth parents facing, or who have faced compulsory removal from the state *or* child welfare services are often forgotten within research and within the adoption triad, with research predominantly focusing on voluntary relinquishment i.e., parents have chosen to place their children for adoption (Broadhurst & Mason, 2017). Historically birth parents have been the most disregarded in literature around adoption (Logan, 1996). Though much of the previous studies have focused on 'voluntary relinquishment' (Winklet & Keppel, 1984; Castle 2010), it is important to note that these were often forced by societal pressures (Howe, Sawbridge & Hinings, 1992). In more recent research, anecdotal evidence suggests that following the removal of a child on compulsory grounds, birth mothers fall too easily outside service provision which begins the cycle of becoming a hidden population (Broadhurst & Mason, 2013). The experiences of birth parents facing involuntary removal may significantly differ to those voluntarily placing their child for adoption.

In Charlton et al's (1998) book, the authors captured the accounts and experiences of birth parents who had faced compulsory removals and adoption. They had reported that most birth parent's physical symptoms following a compulsory removal, were like when facing a bereavement and the cycle of grief. This included sleeping problems, appetite and weight loss, vivid dreams, and flashbacks. These flashbacks were associated with post-traumatic stress disorders (PTSD). Physical complications also extended to ongoing gynaecological problems, abdominal operations, miscarriages, and lengthy phantom pregnancies (Charlton

et al, 1998). One birth mother felt anger towards her second child as it had bought back painful memories of her first child being removed. Her parenting abilities were restricted leaving her frustrated and leading to the removal of her second child. Poor bonding and attachment issues with subsequent children was a central theme for the birth mothers which increased risk of future removals. Charlton et al (1998) reported that the effect of unresolved grief was a great determinant for poorer attachment and bonding in subsequent children. This fits in line with findings from in-depth interviews with 72 birth mothers who described persistent and complicated feelings of grief (Broadhurst & Mason, 2017). Maternal identity felt threatened, and the physical absence yet psychological presence of the children, complicated their grief. If they resolved or accepted the loss of their child, then their maternal identity was compromised (Broadhurst & Mason, 2017). Considering birth mothers are often caught within repeated pregnancies and removals (Broadhurst & Mason, 2017), it can be argued that unresolved grief plays a role in subsequent, involuntary removals. Though both pieces of research were almost 20 years apart, there were stark similarities across them, particularly in relation to feelings of complex grief.

Some qualitative research has been able to provide an insight into birth parent experiences through the child protection process, and their relationships with state services. In a qualitative study Ghaffar et al (2012) found that birth parents reported that they were not readily given information around the child protection procedures and had problems retaining information due to their high levels of stress and anxiety. It is therefore not uncommon for birth parents to not access post-adoption support, because only those who are able to self-advocate are more likely to seek support. More than half of the target population do not use post-adoption services at all, suggesting that birth parents are a hidden population (Broadhurst & Mason, 2013).

In a recent study by Taylor, Mosse & Stanley (2019), researchers explored the experiences of social worker interventions amongst mothers with PMH needs. Eighteen birth mothers were allocated into two groups; high social service intervention (HSSI) and low social service intervention (LSSI). Those within HSSI (n=11) were mainly under the age of 25, had no formal qualification, around half of the group had one child already in care, and had significant mental health disorders for which they were placed within specialist perinatal services. Those in the LSSI (n=7) group had a range of milder mental health problems, all

were living with their partners, and had mainly community support services put in place. However, those in the HSSI group felt they were labelled as bad mothers and as though they were set up for failure. The interventions with a social worker had the possibility of intensifying pre-existing mental health conditions, which supports research by Memarnia (2014) that many mothers who have lost their children to the care system may already have pre-existing mental health conditions and can significantly worsen at removal. In the defence of social workers, they are often stretched, lack resources, and are often faced with difficult dilemma's around ensuring that the child is protected. Taylor et al (2019) concluded that social workers are often pressured to ensure the child's safety and it is not in the best interests to support birth parents too. However, this provides a stronger rationale to ensure birth parents are receiving adequate support too, and social workers working alongside perinatal services can be crucial for recovery and rehabilitation for birth mothers.

Though there is a still a major lack of representation of birth parents of compulsory removals and their experiences within published literature, there has been a rise in acknowledging this issue in the last few years. For instance, in an evaluation carried out by Welch et al (2015) for an independent post adoption agency, birth mothers were interviewed around their experiences of the Chance4change program, a rehabilitation program for birth mothers who had children removed from their care on compulsory grounds. Twenty referrals had been made into this pilot project, with 8 engaging in the program. Four of these birth mothers were interviewed, and interviews were transcribed using thematic analysis. The findings suggested that there were complex adversities, trauma and deprivation embedded within their lives. The birth mothers were angry or ambivalent around professionals and authorities which problematised their relationships with statutory providers. The women were traumatised by the loss of their child and could not comprehend the reasoning behind this. However, the consistent group work therapy offered by Chance4change, and building on healthier relationships with these professionals offered a more positive outlook on life and even had a positive impact on future children. As this was a very small-scaled evaluation, the authors ensured to capture as much in-depth experience as possible from the birth mothers as well as information from case files to supplement their findings. Though small sample sizes may be harder to generalise findings into wider contexts, Ellard-Gray et al (2015) have emphasised that small sample sizes are often an indication of a hidden populations, yet there is value in researching these groups as it can help to provide a voice for groups that often go unnoticed. This was

deemed as a good rehabilitation service that needed to be scaled up to make more sustainable and positive changes for birth mothers.

Academic research around compulsory removals has often been lacking and little attention has been given to the experiences of these birth mothers (Welch et al, 2015). Literature that has provided an insight into compulsory removal experiences has often been limited in sample size due to the nature and sensitivity of the subject (Charlton et al, 1998; Welch et al 2015), or has focused more so on patterns of recurrent removals or birth mother experiences of social work intervention (Ghaffer et al, 2012; Broadhurst & Mason, 2017; Taylor et al, 2019) which is often a negative one. Nevertheless, the research can begin to add to the academic literature surrounding the complex issues birth mothers of compulsory removals may face, with the acknowledgment for more specialist service provisions and support for these women. Yet, there is still gaps in research that ought to focus on the impact that the removal process can have on PMH outcomes, or vice versa, i.e. whether PMH issues can increase the risk on removals, and whether more specialist perinatal teams should be aware of the adversities birth mothers may face.

3.1a Stigma and barriers birth mothers face:

Birth mothers, both through voluntarily and compulsorily removed children, are bound by many negative stereotypes which often means their sense of grief and loss are dismissed and illegitimated, creating many psychological and social repercussions (Memarnia, 2014). A potential reason as to why research around compulsory adoption is so limited may be because these mothers often face stigma by society and therefore are reluctant to access services (Memarnia, 2014; Broadhurst & Mason, 2013). It is important to remember that a significant number of birth mothers may already have pre-existing mental health problems, and in many cases, this contributes to the removal of the child when combined with other psychosocial issues (Memarnia, 2014). Charlton et al (1998) points out that though compulsory removals contribute massively to adoptions, those mothers who have had their children adopted against their own will are unable to represent themselves or have a collective voice about the need for services for them. These mothers are silenced by stigma and the shame of being judged as a flawed mother, along with being fully aware that any future pregnancies will be subject to child protection services being involved (Morris, 2018). Again, their motherhood will continue to be stigmatised by their past.

Birth mothers caught in the child protection system have almost certainly experienced difficult childhoods, and other negative experiences such as physical or sexual violations as well as social-economic deprivations (Broadhurst & Mason, 2012). Broadhurst & Mason (2017) identified that mothers caught in recurrent care proceedings had a high prevalence of domestic violence, substance misuse, mental health issues, housing instabilities, no supportive network and service non-engagement. Despite this knowledge, child protection services very rarely address these women's own victimisation and disadvantaged backgrounds. Where birth mothers become pregnant again following a removal, standard practice will be that a statutory pre-birth assessment will be conducted by the local authority. However, this often occurs late in pregnancy between 26-30 weeks. These decisions are often difficult ones taken by the local authorities because of scarce resources, but on the other hand misses a window of opportunity in relation to the mother's rehabilitation. These mothers may only be given around six weeks to show any signs of positive change during pregnancy leading to a great sense of injustice where they feel that they have not been given the opportunity or time to show any successful change, and understandably increasing anxieties and stress over this period.

Children's services have often struggled to balance understanding the needs of parents but also remaining child focused. Such struggles can make practice inconsistent, and parents needs may be deemed as being 'bracketed' off because they are somewhat seen as dangerous or overwhelming for workers (Broadhurst & Mason, 2013). It has been acknowledged that pre-birth assessments should therefore be carried out earlier to provide an opportunity for mothers to engage with local authority and develop better relationships.

Neil et al (2010) highlighted that mental health symptoms in birth parents facing compulsory removals were at significant clinical levels, suggesting the importance of mental health services to be involved or for workers to be trained around mental health complexities of this group. Whilst the pre-birth window can offer a chance for mothers, there have been consistent reports of birth families failing to engage with the local authority post-removal. In a pilot study, it was evident that several birth parents did not use post-adoption services at all because of their unfavourable assessments around parenting abilities and psychological reports. Mental health problems were present in 80% of the sample yet mental health services were not available in many cases (Broadhurst &

Mason, 2013). Furthermore, repeated removals were seen as being routine within the family system because courts were not able to give enough time to birth mothers to demonstrate change (Broadhurst et al, 2015).

The literature around birth mothers has suggested that not only does the removal of children have long term psychosocial and physical consequences on the mother, but these mothers are also reluctant to access support due to the stigma attached to them, and therefore this can lead to more ongoing psychosocial issues. Due to the lack of trust with professionals and a lack of access of appropriate services for birth mothers, there is a potential that the stereotypes associated with birth mothers are reinforced. Given that many birth parents may have broken down relationships with the local authorities, it should be recommended for relevant mental health professionals to play a leading role in supporting birth parents.

3.2 Perinatal Mental Health:

This section will broadly discuss the distinction between general depression and PMH issues (more specifically postnatal depression), the implications of untreated PMH issues, and how PMH issues can manifest itself due to various levels of severity.

Pregnancy is a time of many physiological and psychological adjustments to prepare for motherhood, and long been considered as a time free from any psychological problems (Apter, Devouche & Graiter 2011). However, more recent evidence now suggests that this can be far from the truth as maternal mental health problems are common and debilitating (Apter et al, 2011; NHS, 2020). In the case of birth mothers who face additional psychosocial issues, maternal mental health matters may be more complex and particular attention may be required to this vulnerable group.

Nicolson (1990) argued that there is a distinction between general, clinical depression and PostND. The research found key outcomes where postpartum directly related to motherhood in terms of physical adjustments, bodily changes, and insecurities about the health of their baby (Nicolson, 1990). Mothers who experience mental health problems after birth may struggle to provide essential care to the new-borns emotional, social, and intellectual development. It has been recommended by Health Education England (2016), that professionals working with pregnant mothers and new mothers should be aware of

signs and symptoms of poor mental health and encourage or support mothers to look after their wellbeing, and to be aware of vulnerable women who may be of increased risks to perinatal mental health problems. This is vital to reduce the impact of perinatal mental health issues and disruptions in bonding with their baby. Despite these recommendations, around 1 in 10 women will experience a perinatal mental health problem after birth (NHS, 2017).

There are many examples of PMH problems, including, prenatal & postnatal depression or anxiety, perinatal obsessive-compulsive disorder, postpartum psychosis, and post-traumatic stress disorder (PTSD). These mental illnesses can all vary in severity, from mild to moderate, and in some cases, severe (Maternal Mental Health Alliance, 2020). If left untreated, there is a high possibility that the problems faced during the perinatal period, will continue into later life, and the cycle may continue to perpetuate. The long-term effects of untreated PMH issues include sleeping and eating disturbances, anxiety, insecure emotions, and suicidal thoughts in some cases. There are also long-term implications on early child development, such as poorer cognitive and emotional function (Maternal Mental Health Alliance, 2020). Though there is no one cause or trigger for the onset of perinatal problems, the Royal College of Psychiatrists (2017) explain that a woman is more likely to experience problems during pregnancy or after birth if she has had a previous history of mental health problems, there is a lack of family or social support, or has recently experienced stressful life events including a traumatic birth. Other risk factors around PND include poverty, childhood abuse, domestic violence, alcohol or drug use and migration status (Pearlstein et al, 2009).

Developing PMH problems is influenced by a myriad of factors, and unclear as to what increases the risks of the severity of the problem. However, there is a great need for professionals to support vulnerable woman who may be at a higher risk of developing PMH problems not only to prevent long term consequences in mothers, but also prevent developmental consequences in children. Recognising signs and symptoms of PMH issues may help to portray a picture around the severity of the issue, and in turn help professionals to provide the right support to women. The next section will discuss signs and symptoms of PMH.

3.3 Signs & Symptoms of PMH issues:

Signs and symptoms of PMH issues can manifest themselves in many ways. Like any mental health issues, there can be many signs and symptoms, and can be seen to be on a spectrum (Very Well Mind, 2020). This section will introduce 'baby blues', a common phenomenon causing women to feel low due to an imbalance of hormones following childbirth (Baby Centre, 2018). This section will also focus more specifically on introducing PMH issues, along with signs and symptoms associated with postnatal depression and anxiety (PostND/PostNA), followed by perinatal psychosis.

During the first week or so after childbirth, around 8 in 10 women may experience 'baby blues' (Baby Centre, 2018). Along with feeling low, this phenomenon may cause women to feel emotional, anxious, tearful, extremely tired but can be explained by the sudden hormonal and chemical changes following childbirth. This usually stops after a few days postpartum (NHS, 2017). If however symptoms persist and amplify for two weeks or more, this may be an indication that a mother is developing PostND/PostNA (Public Health England, 2017).

PostND is a clinical type of depression and a common type of perinatal mental health issue effecting around 8.5-11% of the Western, female population (Masood et al, 2015). It can be described as a depressive illness after having a baby (Royal College of Psychiatrists, 2017). Unlike general depression which can occur at any stage in life, PostND does have certain characteristics. Firstly, and most evidently, PostND occurs after childbirth and up to one year later (NHS, 2017). Experiencing childbirth can bring along many changes and the transition to motherhood can consist of many bodily, social, and psychological changes. For some, this may mean being sleep deprived and therefore feeling fatigued, she may have trouble breastfeeding and being hormonally unsteady. The mother may begin to be consumed with guilty thoughts, and feelings of disappointment as she is not meeting societal expectations of motherhood. (Acacia Family Support, 2020; Northamptonshire Healthcare, 2020).

In a qualitative study by Hall (2006), 9 out of 10 mothers reported their feelings around being a bad mum and felt that others would be able to do a better job. Along with experiencing negative thoughts about her ability to be a good mother, she may also have worrying thoughts about harming her child and/or excessive anxiety about the baby. This is known as postnatal anxiety (PostNA) (NHS, 2017; Baby Center, 2017). In seven interviews

with mothers, PostNA was filled with anxiety attacks, obsessive thinking, and contemplated harming their infants (Beck, 1992). Symptoms such as these may be classified as a higher severity of PMH issues. Other symptoms similar to common depression or anxiety, can include a persistent feeling of sadness, loss of interest in social activities, low self-esteem, and confidence, feeling agitated or irritable, anxiety, aches and pains, loss of appetite and feeling generally unwell (NHS, 2017). Whilst many are aware of PostND/ PostNA, prenatal anxiety and depression is also highly common (PreND/ PreNA). Signs and symptoms are similar to that of postnatal anxiety or depression, but mothers may also have anxiety around childbirth or show signs around difficulty bonding with unborn baby.

Although less common than pre or postnatal depression and anxiety, it is also important to note that 1 in 1000 women will also experience perinatal psychosis. Perinatal psychosis can often occur within the first few weeks after birth, and those mothers with a history of psychosis, are at higher risk of developing this. The symptoms can be similar to that of bipolar disorders, schizophrenia, racing thoughts and paranoia, feeling suicidal or planning suicide (Tommy's, 2020).

In summary, PMH issues can be seen to be on a spectrum with an array of signs and symptoms influenced by many biopsychosocial risk factors. PMH issues mirror that of general mental health problems such as anxiety and depression, however the distinct difference is that there is now a child involved (Nicolson, 1990). Childbirth, and motherhood can bring about many other biopsychosocial changes, which in turn can influence the severity of PMH issues. It is therefore very important for women to be screened as early and as often as possible during pregnancy and after birth around PMH issues so that the appropriate support can be offered and prevent any long-term negative outcomes. The next section will look at the literature surrounding the risk factors associated with PMH issues.

3.4 Risk Factors of developing PMH issues:

This section will cover the biopsychosocial and cultural practices as risk factors for the onset of PMH issues. More specifically, the psychosocial risk factors will focus on literature around previous history of mental health, maternal age, social support, termination of breastfeeding as risk factors for the development of PMH issues. The biological risk factors will specifically focus on hormone fluctuation, and genetics. Each of these risk factors will draw on research around birth mothers. This chapter will also particularly focus on whether cultural practices during the perinatal period are protective or risk evoking in the development of PMH, and literature around the ethnicity of children within child protection and adoption research in the UK are considered.

Risk factors are any attributes that may increase the likelihood of the condition developing (WHO, 2018). There can be an array of symptoms which can be split into three categories of severity: mild, moderate and severe. In a review by Andrews-Fike (1999), categorising the symptoms in terms of severity can help with specific treatment methods. However, to understand the severity of PostND, it is important to know what risk factors may trigger the onset of PostND (Andrews-Fike, 1999). Beck (1998) reported the following as risk factors for the onset of PostND. PreND was found to be a significant predictor for the onset of PostND as was childcare stress, lack of social, emotional and practical support, recent life stresses, marital dissatisfaction and having a history of previous depression where relapse was as high as 50%. As stated by Andrews-Fike (1999), many of these risk factors are largely social ones. But when interpreting factors around psychiatric or psychological illness, it is valuable to remember that it is highly likely that there is no one single cause (Robertson, Celasun & Stewart, 2003). Additionally, pregnant or new mothers represent a specific group where both hormonal or biological and psychosocial events are happening in parallel and therefore it can be difficult to distinguish from the two (Sylven, 2012).

3.4a Psychosocial and cultural factors:

Previous history of mental health problems

Beck (1998) pointed out that there are several social and psychological factors that can increase the risk of PMH issues. A previous history of psychological or psychiatric disorders have been associated with an increased risk of PostND. In a meta-analysis of 84 studies looking at the predictors of PostND, 13 significant risk factors were thought to increase the onset of these issues. One of which was PreND (Beck, 2001). The chances of developing

PreND are increased when a mother is experiencing recent stressful life events such as domestic violence, financial worries, unplanned pregnancies, along with previous history of mental health, or, having no social support from family or friends. Research has shown that domestic violence, mental health problems and substance misuse were present 65%-90% cases of children in need (NSPCC, 2016). Together these issues can make it extremely difficult for parents to prove a safe and caring environment. This could also suggest that experiencing these problems can increase the chances of severe PMH problems in birth mothers.

Maternal age

The relevance of maternal age has been debated in relation to the onset of PostND/PostNA. The research has been mixed in terms of supporting, and not showing, an association between maternal age and PostND. For instance, some studies have supported that a younger generation is at higher risk of developing PostND. Katon, Russo, Gavin (2014) examined the predictors of PND in a study sample of 1423 pregnant women. Women with PostND were significantly younger compared to women without PND. Wang, Tiejian, Anderson, Florence (2011) examined maternal depression status from birth to 36 months. Mothers aged between 18 and 24 years of age had a higher prevalence of early and long-term depression in comparison to other groups.

In the context of birth mothers, Broadhurst & Harwin (2018) highlighted the experiences of women who had children removed from their care from 11000 mothers. Forty percent of these mothers had been in care themselves and many of which had their first child within their teenage years. There was often a relatively short gap between subsequent children which did not adequately allow for time to demonstrate positive change.

Broadhurst et al (2017) also identified that those mothers caught in repeated care proceedings were aged 20 or less at the birth of their first child. Some of the prevalent issues within the report highlighted that these mothers were subject to domestic violence, substance misuse and mental health problems (Broadhurst et al, 2017). This may suggest that these young mothers with children within care proceedings are at a higher risk of developing PMH problems, and particular care would need to be taken in those entering the care system again.

In contrast, some research has also found that the transition to parenthood later in life is a risk factor for the onset of PND. Boivin et al (2009) looked at the impact of maternal age at first birth against several outcomes including wellbeing. The mothers in the older age group were significantly more depressed compared to the younger group. This remained significant even when controlling for education and income.

Other research has indicated that there is no such association between maternal age and PostND. The Parental Age and Transition to Parenthood study Australia (PATPA) program examined the experiences of new mothers and found that the maternal age did not increase the risk of PND (McMahon et al, 2015).

Though there is conflicting evidence between maternal age and PostND, it can be suggested that younger mothers experience higher levels of stress, low self-esteem, unwanted pregnancies and financial burdens, and are less likely to share their worries because of thoughts that their children may be removed (Mental Health Foundation, 2013; Public Health England, 2018). Furthermore, Broadhurst et al's (2017) large scaled study showed that almost half of the young mothers themselves were in care themselves and had faced difficult upbringings, impacting their parenting abilities. On the other hand, PMH in older mothers could be explained by a couple of factors. For instance, parenting at an older age combined with perimenopausal symptoms may have accounted for PMH issues (Boivin et al, 2009). Additionally, and although a more secondary factor towards PMH issues, older women in longer relationships have shown that there is generally a decline in warmth and affection between partners, leading to lower parental wellbeing (Laningham, Johnson & Amato, 2001; Boivin et al, 2009). Nevertheless, maternal age seems to be a conflicting factor in the development of PMH issues.

Social support

A large prospective study examined the risk factors of PMH issues in an Australian population. Low support from partner was found to be a risk factor for PostND (Milgrom et al, 2008), consistent with findings from an earlier meta-analysis where a lack of social support was a predictor of PostND in 27 studies (Beck, 2001). Partner violence is also a form of low social support and is a worldwide concern predominately affecting women of reproductive age (Beydoun et al, 2010). In a large-scaled sample of women (n=8542) aged

15 and over, PostND was significantly higher in those who had experienced partner violence in the past two years compared to those who did not (Beydoun et al, 2010).

It is important to remember that social support is a multidimensional concept in that there can be many sources of support, i.e. other family members, friends, colleagues (Robertson, Grace, Wallington & Stewart, 2004). Negron et al (2013) investigated the views of 33 women from an ethnically diverse population. All women revealed that support from partners, family and friends was essential for their physical and emotional recovery and more importantly that this support should be provided without asking. This study suggests that identifying the needs of mothers and providing social support without the need to ask is important in helping with recovery after childbirth.

In the context of birth mothers, a lack of social support seems to be a common occurrence. In a report by Broadhurst et al (2017) 72 interviews were conducted on birth mothers, whereby 35 of them had received low levels of social support throughout their adulthood and 25 mothers faced instability with their housing situation. Domestic violence, particularly in young mothers was also a common occurrence (Broadhurst et al, 2018). From quantitative data analysis of 354 mothers, 105 faced having no supportive networks, and 144 had housing instabilities, highly increasing the risks of reoccurring removals (Broadhurst et al, 2017). The Pause Project, a UK wide organisation supporting birth mothers entering recurrent removals, have also found that 1 in 4 women who have had a child removed are more likely to have subsequent pregnancies and this is three-fold for teenage mothers (Pause, 2020). Pause (2020), also note that there is a high prevalence of complex factors when it comes to the removal of children, with domestic violence, substance use, homelessness, and experiences of growing up in care to be significant risk factors. Furthermore, statistics have shown that birth mothers had faced multiple adverse experiences within their own childhoods, particularly neglect or child maltreatment by their own parents or caregivers which made them vulnerable to victimisation outside the home. This can have serious consequences around developmental and intergenerational trauma.

Culture and Ethnicity:

The physiology of pregnancy and birth is the same all around the world, however the experiences, social networks, practices can be very different (Roberston, Celasun &

Stewart, 2003). Whilst there may be many different explanations and rationales for postnatal practices amongst cultures, the underlying theme across all is the restoration of the mother's health. This is in contrast with Western medicine where the focus is on infant health and wellbeing (Dennis et al, 2007). However, the pre and post birth practices within cultures may also be seen as a sign of respect to ancient traditions and religious practices and therefore women may feel obliged to carry these out.

Bina (2008) highlighted that a *lack* of cultural traditions can act as a deteriorating factor in depressive symptoms. Researchers (Haung & Mathers, 2001; Nahas & Amasheh, 1999) found that having a lack of support from close family meant the women became overwhelmed with responsibilities and felt that they failed to be a good mother and wife. Both studies have demonstrated that even if living in a modernized or Western culture, it was important for the mothers to be able to follow traditional practices even without the customary support. This strongly supports the notion that social support through family or friends is an essential component in physical and emotional recovery (Negron et al, 2013).

In a qualitative review looking at traditional postpartum practices and rituals, many commonalities emerged (Dennis et al, 2007). The notion of organised support for the mother, i.e., a mother being mothered, seemed to be prevalent amongst South Asian and South East Asian, Guatemalan, and Nigerian cultures. Usually, a female family elder would provide care to the mother and baby, most commonly in the form of practical support (household duties). They may also advise the mother on how to care for their newborn. Organised support and rest periods can be seen to correspond together and during the rest period a mother would be restricted in performing her usual duties, which can span between 21 days to 5 weeks. These mandated rest periods and organised support practices are designed to allow the new mother to rest and recover based on ancient scientific philosophies (Bina, 2008; Nutrition care of Rochester, 2021). Other practices such as dietary and bathing customs were also considered to be physically and emotionally healing for new mothers. Many of the studies within the review suggested that organised support, rest periods and prescribed foods to help with recovery of the mother, played a significant role in preventing symptoms of PostND and that a lack of this kind of support increased the risks of parental mental health issues.

Despite many protective practices amongst different cultural groups, in a recent report by NIHR (2019), around 1 in 5 will experience a maternal mental health problem, with these rates increasing if a woman is from a non-White British group. The large-scale report found that White women are more likely to be offered maternal support compared to Black and Asian women. There were also barriers for non-White British women in accessing appropriate services such as language barriers, cultural appropriate resources, lack of representation or female led staff. Emotional isolation was also experienced by non-White British women, and some felt a lack of support from their partners. Rituals or traditions may be adopted in some cultures to protect against depressive symptoms, however in today's society, with increased immigration and modernization, some rituals and traditions may be harder to practice or may conflict with the dominant culture.

Within the UK, the statistics around the profile of looked after children are as follows; 75% were of White British origin, with only 7% from a Black background, 5% from an Asian background and 3% from other ethnicities (Department for Education, 2017). It can be questioned as to whether pre and postnatal cultural practices may act as protective factor from developing perinatal mental health problems, and perhaps suggests why there are lower numbers of looked after children from non-White British ethnicities. However, it is crucial to acknowledge the guilt / shame paradigm within the context of these studies. People in guilt-based cultures generally base their behaviour on what rules ask them to do, and their inner conscience guides them to decide whether what they have done is good or bad (innocent or guilty). Within a shame-based culture people are generally influenced by a collective or community-based opinion (Strucely, 2018). According to Strucely (2018), Asian and Middle Eastern cultures are especially shame-based cultures. This supports the studies outlined within the review where communities or families will come together to protect the whole 'group'. This suggests that although these are collectivist communities where cultures are concerned with the good of group, there are extreme pressures to live up to these standards, and when these standards are not met, shame will be bought on the whole community, group or family. Perhaps this a reason as to why children of ethnic minority parents are under-represented (DoE, 2017) because a collective approach can be protective, but on the other hand, these families fear shame, and therefore may not be open to disclosing issues to professionals.

Termination of breastfeeding:

Breastfeeding is an interesting topic due to it having effects on both mother and child. Watkins et al (2011) found that women who disliked breastfeeding in the first week postpartum were more likely to be depressed at 2 months. Women who had severe pain from breastfeeding on the first day until the second week postpartum were also more likely to be depressed. Dennis & McQueen (2009) qualitatively reviewed the relationship between PostND and infant feeding outcomes. The findings revealed that early symptomology of depression during the perinatal period had a negative impact, with increased risk of poor infant feeding outcomes. This included decreased breastfeeding, increased breastfeeding difficulties and lower levels of confidence around breastfeeding. Though the research indicates that there is a relationship between breastfeeding and PostND, it is difficult to determine whether it is the depressive symptoms having an effect on negative breastfeeding or vice versa.

In relation to birth mothers, some research has indicated that decreased or early termination of breastfeeding increases the risk of PostND (La Leche League, 2020). Birth mothers going through care proceedings or who have a child within foster care are often faced with the reality of abruptly ending breastfeeding, which may have serious consequences on both mother and child. Although there has not been extensive scientific literature specifically around the termination of breastfeeding in birth mothers through care proceedings, one US based study had found that infants had more insecure attachment styles when the child (under the age of 12 months) had spent one or more nights away from their mothers who were breastfeeding (Tornello et al, 2013). A breastfed baby may become more distressed if separated from their mother, increasing cortisol levels which can lead to long term problems (La Leche League, 2020).

Research around this topic raises questions around whether early removal of children within birth mothers will prevent them from breastfeeding, consequently increasing their risks of developing PostND. The Guardian (2018) released an article around birth mother's experiences of having children removed only 15 minutes after birth, with no chance to breastfeed. One birth mother within the article explained that she could visit her new-born at the foster carers home before being placed with adopters, but had no opportunity to breastfeed (The Guardian, 2018). Denying these natural maternal rights led the birth mothers to experience significant psychological problems. The lack of published research around this topic area present difficulties in understanding the multidimensional issues

around breastfeeding cessation within birth mothers in care proceedings or the removal process. Again, this provides a rationale to research the experiences of birth mothers of compulsory removals and the risk factors around PMH issues.

3.4b Biological and Genetic factors:
Biological risk factors

There has been evidence to suggest that thyroid function abnormalities, hormone abnormalities, and the activity of the HPA axis (complex interactions between three glands) can be linked with an increased risk of PMH issues (Basraon & Costantine, 2011). Thyroid hormones can have a multitude of effects. For instance, an overactive thyroid may cause someone to feel restless, anxious or irritable, but an underactive thyroid will do the opposite and a person would show signs of fatigue or depression (Mayoclinic, 2017). Fluctuations around the hormone estrogen during pregnancy can reduce the activity of the HPA and is known to play a role in depressive symptoms (Osterlund, 2010). Corticotrophin-releasing hormone (CRH) is a hormone involved in the stress response and the regulation of the HPA axis. In short, high levels of the hormone can suppress appetite and increase anxiety (Society for Endocrinology, 2017).

During pregnancy the levels of CRH are increased and binds with its corresponding protein (CRH-BP) to regulate its concentration (Kammerer, Taylor & Glover, 2006). However, during the last six weeks of pregnancy, concentration of the binding protein depletes resulting in free CRH. This rapid fall in the protein and elevated free CRH are thought to be correlated with pre-eclampsia and premature delivery, but also the start of labour in full term pregnancy (McClean et al, 1995). Furthermore, the increased concentration of CRH can possibly lead to the increased risk of PostND (Kammerer et al 2006). With pregnant birth mothers going through care proceedings, or within the cycle of recurrent removals and traumatic or stressful situations, it is vital to be aware that they may at an increased risk of having premature births, and mothers of premature births are thought to have shown greater psychological distress compared to mothers of full-term infants (David, Edwards, Mohay & Wollin, 2003). These increased stress levels may have a negative impact on child development.

Genetic risk factors

Genetic factors have been thought to be implicated in the aetiology of PMH issues. In a pilot study by El-ibiary et al (2013), researchers evaluated both genetic and environmental factors around the development of PostND. Mothers were screened six weeks postpartum using the Edinburgh Postnatal Depression Scale and were then recruited as cases or controls. Twelve genes were selected for analysis through blood sampling. The results revealed promising statistical associations of PostND with a range of genetic and psychosocial factors. Relationships between estrogen and serotonin influenced whether mothers had postpartum depression and other genes closely associated with OCD behaviours.

The researchers also found strong psychosocial associations relating to distressed relationships, perceived lack of social support and previous history of mental health problems. This is particularly useful for social workers to take into consideration within care proceedings. Many birth mothers may present pre-existing mental health issues. As pointed out earlier, 53% of 175 serious case reviews, indicated parental mental health problems (Sidebotham, 2016). This raises the questions as to how many of these birth parents carry genetic coding to increase the risks of developing mental health issues, yet mental health services are not readily available for birth parents.

3.5 PMH issues and Child development

It has increasingly become clearer that maternal PMH issues is one of the most crucial determinants of a child's wellbeing. PMH issues have been linked with consequences around a child's physical and emotional development (Education Policy Institute, 2020). This section will look at existing literature that supports how PMH issues can have an impact on a child's cognitive development, and that early identification and treatment is beneficial to both mother and child.

Both pre and postnatal PMH issues are thought to have significant consequences for both mother and child (Letourneau, Dennis, Cosic & Linder, 2017). Prenatal PMH issues are considered to disrupt the maternal neurocognitive changes that occur in early and late pregnancy associated with the ability for mothers to appropriately respond to infant cues (Pearson, Lightman & Evans, 2011). These conditions can explain poorer mother-infant interactions and insecure attachments, hence there is a large emphasis from perinatal organisations to support mothers during the prenatal phase too (Maternal Mental Health Alliance, 2021).

There has been ample evidence to suggest that PMH issues can lead to poorer attachment styles (Field, 1984; 1985; 1990 Cohn et al, 1986). More recent evidence supports this notion. For example, parental distress during pregnancy impacted both cognitive development in children at 14-19 months, and fearfulness in infants. Partner relationship strain was the largest factor in parental distress (Bergman, Sarkar, O'Connor, Modi & Glover, 2007), which is a factor that is commonly experienced by birth mothers (Broadhurst & Mason, 2017). Postnatal mental health issues also have significant consequences on mother and child because depressed or anxious mothers often are unable to respond to the needs of the child and alleviate their stress, resulting in less positive feedback and poorer attachment styles (Cooper & Murray, 1997). In a study by Field (2010) mothers with postnatal depression were less likely to engage in play time, be nurturing and positive during face-to-face interactions and were more likely to impose harsher punishments. These maternal responses have been linked to poorer attachment styles in infants, lower self-esteem, and developmental delays (Fearon & Cooper, 2015).

Field et al (1990) assessed interactions in 48 depressed and non-depressed mothers. The depressed mothers and infants were matched to negative behaviour states compared to the control group. It is important to note that this research was conducted on women from poorer socio-economic backgrounds, and either teenage mothers or single mothers. In relation to birth mothers, the demographics of Field et al's (1990) sample somewhat align to the characteristics of birth mothers caught in repeated care proceedings. Broadhurst et al (2017) highlighted that the proportion of women that typically enter repeated cycles of removals are young mothers from disadvantaged socio-economic backgrounds. Furthermore, there has been increasingly more evidence to suggest that poverty may influence PMH issues and in turn have an impact on a child's development (EPI, 2020). Again, this fits with Broadhurst et al's (2017) findings whereby birth parents caught in repeated cycles of removals are often from disadvantaged backgrounds. Michigan State University researchers were one of the first to find a strong association between domestic violence, PostND and trauma symptoms within the first year of their child's life. This included nightmares, being bothered by bright lights and noises, having trouble experiencing enjoyment and avoiding physical contact (Levendsoky & Henion 2014). This is a crucial finding that needs to be considered within recurrent care proceeding meetings, as many birth mothers often experience domestic abuse.

There is a wealth of evidence to suggest there is a negative impact on children's development through untreated PMH issues and that an early diagnosis and treatment will help prevent long term outcomes in children too. However, the research just simply amplifies the need to prevent poor maternal mental health outcomes in the first place and to identify the risks associated more specifically to birth mothers.

3.6 Overview of existing literature:

Existing literature around birth mothers of compulsory removals seems to be quite sparse but has demonstrated the grief and loss women endure which is often dismissed by society. Research around voluntary and compulsory removals have provided an insight into the long-term consequences birth mothers are faced with, including consistently being marginalised and stereotyped by society and professionals. The stigma attached to birth mothers may hinder birth mothers from accessing support when required, but also prevents them from creating trusting relationships with professionals. The long-term

biopsychosocial effects that the women endure after the removal has the potential to impact subsequent pregnancies and the developmental outcomes of children (Charlton et al, 1997; Broadhurst & Mason, 2017). It is also important to note that the causes of removals in the first place are often due to a myriad of psychosocial risk factors which mirror the risk factors of PMH issues. With the relevant research taken into consideration, it is evident that PMH problems is a complex mental health concern with a significant number of risk factors effecting both mother and child. Due to the lack of research within birth mothers of compulsory removals, it seems valuable to understand the risk factors which may impact the development of PMH issues within this group of mothers, to potentially prevent long-term psychosocial consequences, and in turn removals.

4.0 Rationale:

Although symptoms, risk factors and the effects of PMH have been widely recognised through literature, it is important that those most vulnerable to developing PMH issues are recognised early on too. Furthermore, with more recognition that perinatal loss can have an increased risk on experiencing PMH issues, it seems crucial to understand this from the context of birth mothers who experience compulsory removals. Birth mothers may also be at significant risk of developing PMH problems due to complex risk factors which may differ from other populations of women, and untreated or unacknowledged PMH problems may also further increase the risks of poorer future parenting. It seems vital therefore to assess PMH problems within birth families and to be vigilant in those families where children have been removed more than once.

To provide effective support to birth mothers of adopted children, or to those who have had multiple removals, it is important to understand birth mother's experiences and emotions through the adoption process and events leading to the removal. Understanding their experiences could highlight any unique risks that they may have faced which increased the chances of PMH problems, and potentially prevent future removals. Professionals could be educated, and awareness could be raised around PMH issues, and the risk factors this particular group faces. To date, no such research has investigated what the risk factors around developing PMH issues in this specific cohort may be. Birth mothers may experience certain psychosocial risk factors that increases the likelihood of PMH issues compared to the normal population of mothers. Statistics and figures demonstrate the psychosocial issues that birth parents face, yet they are the least studied and understood within the adoption triad.

5.0 Research Question:

In line with the rationale above, the research questions will be:

- To investigate what the likelihood of developing PMH issues are within this specific group of birth mothers.
- To consider what are the prevalent psychosocial risk factors around developing PMH issues amongst birth mothers of compulsory adopted children, by exploring the experiences of these birth mothers.

6.0 Aims & objectives:

The aims and objectives will be to:

- Explore the likelihood and severity of PMH issues in this population of birth mothers of adopted children using a quantitative measure, EPDS- Lifetime scale (Meltzer-Brody et al, 2013) and conduct follow-up interviews.
- Explore existing knowledge and personal experiences around the signs and symptoms of PMH issues, and at what point were they present within this group of birth mothers of adopted children.
- Explore existing knowledge and personal experiences around the risk factors of PMH issues and what prevalent risk factors may have increased the likelihood of PMH issues.
- Explore whether risk factors or symptoms worsened during the adoption or removal process, and what support, if any, was present.
- Understand the journey and experiences of subsequent pregnancies within this group of birth mothers and if symptoms of PMH were present in these subsequent pregnancies/ birth.

7.0 Methodology:

This research took a mix-methods approach. By using the EPDS-Lifetime scale (Melzter-Brody et al, 2013) it was possible to measure the likelihood of PMH issues within this group of birth mothers (stage 1). The scale also captured data around age, how many pregnancies the birth mothers experiences, what treatment if any they received for their PMH issues. This was then followed up by conducting interviews and analysing them using thematic analysis (stage 2). This chapter will introduce the researcher's epistemological standpoint within this research, recruitment methods, including where the participants were recruited from, the inclusion and exclusion criteria and challenges around recruitment. This will then be followed by sub-sections on ethical consideration, consent, confidentiality, and support for distressed mothers throughout the duration of data collection.

This chapter will also discuss the study measure used, EPDS-Lifetime (Meltzer- Brody et al, 2013), and how it has been adapted from the original scale by Cox, Holden & Sagovasky (1987). More specifically the sub-section will consider the validity of original scale, how cut-off scores on the scale should be interpreted, and the internal consistency and reliability of the new, adapted scale. The reasoning behind using thematic analysis will also be introduced, and finally data collection methods.

7.1 Epistemological position

I took a pragmatic position which helped to shape the methodology within this research. A major underpinning around pragmatic principles is that reality is based around beliefs and habits which are largely socially constructed (Yefimov, 2004). As a research paradigm, pragmatism gravitates towards solving practical problems in the real world. Another significant underpinning of a pragmatic position is that knowledge is always based on experience and our perceptions of the world are influenced by social experiences. Much of this knowledge is shaped by socially shared experiences i.e., all knowledge is social knowledge.

Unlike positivistic researchers who are likely to adopt a quantitative standpoint, and constructivists who will take on qualitative methodologies, pragmatism has the ability to embrace the two extremes, and allows researchers to be more flexible and reflective in research designing. Due to my pragmatic standpoint within this research, I adopted a

mixed-methods approach. The overall purpose of a mixed-methods approach is to combine quantitative and qualitative data to strengthen the rationale of a study or the results (Schoonenboom & Johnson , 2017). Halcomb (2018) discussed that a mixed-methods approach should only be used when data obtained both qualitatively and quantitatively provides fuller answers to the research question than if they were obtained alone. However, this can often require time and resources to obtain rich and meaningful data using both methods. Overcoming this barrier was by using an existing validated scale for the quantitative data collection. Furthermore, Schoonenboom & Johnson (2017) have also argued that it is important to also recognise the timing of how the two methods are used and integrated within the study. For example, does a researcher simultaneously conduct both the qualitative and quantitative data collection, or is it sequential i.e., one method leads to another? Some studies are sequential by nature whereby it is possible to obtain quantitative data which can then help form qualitative interview questions (Schoonenboom & Johnson, 2017).

This research was a predominantly qualitative weighted, sequential mixed-methods design. This meant that quantitative data informed qualitative design, with qualitative techniques being of higher weighting. The scale used during the quantitative data collection was not merely just a screening tool, as the scale informed questions that could be asked during the interview stage. This made it sequential (Qaunt → QAUL). For example, I was aware that for some of the birth mothers reading skills did not come as easily as it did for others, the scale was therefore completed with assistance. This created conversations around the specific statements within the scale such as age of removal, repeated removals and the type of support that was offered. It felt valuable as well as important to use these conversations as a way to inform the interview schedule whilst ensuring I kept to the aims and objectives of this research.

There is a strong connection between a pragmatic stance and health and social care research. I was fully aware that I was an outsider in researcher, however I was not going into this research with no awareness. I had worked in the field of post-adoption and very often I felt that the needs of birth parents were rarely met. If I searched for adoption support, it was extremely rare to come across anything related to birth parents. Pragmatism is focused on future outcomes and this philosophy is orientated around equality and democracy. Therefore, I approached the methodology of this research with

the focus of understanding the whole picture of a birth mother, including their history and psychosocial risk factors around perinatal mental health.

7.2 Recruitment

7.2a Participants

With a lack of independent support agencies for birth parents, and After Adoption being the lead post adoption, and an independent support agency for birth families, all participants were recruited from After Adoption. After Adoption was a UK-wide voluntary organisation. Due to funding cuts and regional changes, After Adoption closed in 2018. After Adoption had been running a support group project specifically for birth mothers, Breaking the Cycle (BTC). BTC aims to help break the cycle of future adoptions and build a positive future for mothers who have faced difficult situations. This is done through six one-to-one therapeutic and intensive sessions focusing the individual's life journey, their relationships, and their aspirations. This is then followed by six group work sessions focusing on more generic issues such as depression, stress, self-esteem, building healthy relationships, and healthy lifestyles. For the purpose of this study, women were contacted via the project within the agency, BTC.

The mothers had generally been good at engaging with BTC in order to make positive futures for themselves. The BTC workers were briefed around the study aims and the purpose of the EPDS-lifetime (Meltzer-Brody et al, 2013) scale so that they were able to explain this to the women at drop-in sessions. I had also been invited to drop-in sessions to discuss the research project. If birth mothers were interested in taking part in this research, BTC workers and/or the lead researcher worked with the women to complete EPDS-lifetime screener tool (Meltzer-Brody et al, 2013) at the drop-in sessions. BTC staff also discussed the project to birth mothers within one-to-one sessions and provided the screening tool to those women who wished to take part.

7.2b Inclusion and exclusion criteria:

The purpose of this research was to determine the likelihood and the risk factors of PMH issues that a vulnerable group of birth mothers may face. Therefore, all the participants were required to be female birth mothers who had at least one child removed to adoption. The research was also focusing on compulsory adoptions as opposed to voluntary removals

because compulsory adoptions have often been disregarded in research from a birth parent's perspective and may present different experiences to voluntary removals. Those birth mothers who were currently within care proceedings were not included as they would have faced additional stress in taking part, and this study was focused on obtaining retrospective accounts of birth parents. Though the majority of birth parents within the UK are of White British origin, those from other ethnic or cultural backgrounds were not excluded. Those birth mothers who BTC felt were too vulnerable or may not have endured the questionnaires or interviews due to traumatic experiences were not asked to take part. Through conversations between the lead researcher and BTC staff, those identified as having learning disabilities or severe psychological distress were also excluded from the research. It is also important to note that all birth mothers had, or were having an intervention through BTC at the time of recruitment. This potentially meant disregarding birth parents who were currently going through care proceedings, and those who may have had perinatal mental health problems during the proceedings.

7.2c Challenges around recruitment:

After Adoption was aware of this research project as the lead researcher had previously worked for the organisation, and directly with birth parents. Therefore, the lead researcher was supported to conduct research, provided that appropriate measures around confidentiality and ethics were taken into consideration. Though it was initially presumed that many women who had been a part of BTC would wish to take part within this research (>25), it quickly became apparent that it would be difficult to recruit this many woman. A total of eight participants from BTC initially came forward to take part in the stage 1 of this research. Though this number of participants was lower than expected (as >25 women had been on BTC), home addresses and telephone numbers of previous birth mothers had changed from when they first used the service, and therefore BTC staff had found it difficult to engage or contact previous birth mothers to explain the purpose of this research. Instead, many birth mothers were recruited from the current cohort of BTC. Challenges around recruitment will be discussed further within the discussion section.

7.3 Ethical Considerations

7.3a Ethical Approval

An initial ethical application had been provided to the UWE ethics committee in January 2018, and an approval with conditions had been granted in March 2018. One of the conditions required obtaining a written and signed agreement from After Adoption to verify recruitment of birth mothers from their organisation. I obtained this signed consent in July 2018 and shortly after, ethical approval was granted (July 2018). All relevant documents are provided in appendix C.

7.3b Informed Consent

Informed consent was taken during stage 1 of data collection. All birth mothers that agreed to take part provided both verbal and written consent. All birth mothers within the research were provided an information and consent sheet (see appendix D & E) which also included a participant number. The consent form was informative of what they would be agreeing to, but with BTC's advice it was kept simple. The information sheet was read out aloud to the birth mothers who had agreed to take part, either by the lead researcher or BTC staff. This allowed birth mothers to ask any questions. The consent form was then signed by the birth mother and kept at the After Adoption office. Once signed, BTC kept an electronic document where the participant number corresponded to a birth parent code. The participants were reminded about withdrawal and time frames to do this in. During the interview stage (stage 2), the consent form was retrieved and was read out aloud again for an opportunity to ask questions, or if the birth mothers wished to withdraw.

7.3c Confidentiality:

Information in relation to confidentiality was verbally explained at the same time as providing the information sheet. The information sheet also included a written section on confidentiality. The participants were informed that no real names would be mentioned within the research however they would be provided a pseudonym within the research, and a participant number to refer to. The signed consent form was kept at the After Adoption office on each birth parents file and they were given the information sheet to take home. The completed EPDS-lifetime scale was kept by the lead researcher. Only participant numbers were on the screener scale and therefore the lead researcher kept this within a locked filing case. They were also informed that all the interviews would be recorded on a recording device and would be transcribed and recorded data would be destroyed as soon as transcription was complete. They were reassured that the

transcriptions would be kept in a password protected computer that only the lead researcher would have access to. Being service users, the birth parents were aware of policies around After Adoption's confidentiality agreements. Birth mothers were also aware that if there was a concern around their wellbeing and safety or someone else's that they mention within the interview, then as a researcher there would be an obligation to breach confidentiality and inform BTC staff, if they were not already aware.

7.3d Support for any distress

BTC had agreed that if birth mothers felt they needed additional support post-interviews, then they would be able to provide this. Furthermore, information regarding PND was given to each woman on how to manage signs and symptoms and where to access support (Acacia Family Support). All the participants were aware that they could stop the interview at any time if they found it distressing, and after each interview time was allocated for an informal debrief where they were encouraged to speak to BTC staff if they found anything distressing. If from observations it was felt that the participant was becoming uncomfortable or distressed, then the interviews would be paused.

7.4 Study Measure:

7.4a Edinburgh Postnatal Depression Scale (EPDS) (Cox et al 1987):

At present in the UK, the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al, 1987) is considered the gold standard for the initial detection of PND and is the most common tool used amongst midwifery practice, and is validated (British Journal of Midwifery, 2020). It can be used both prenatally and postnatally. The development of this tool was devised after extensive pilot interviews in 84 mothers around their perinatal mental health issues. The rationale behind the EPDS scale was to help professionals (midwives and health visitors) who are uniquely placed within health care to identify poorly mothers.

The authors of the EPDS scale identified that existing depression scales were not able to identify PMH problems in mothers. For instance, the Anxiety & Depression scale (Bedford & Foulds (1978), Beck Depression scale, and the General Health Questionnaire (Goldberg, 1970) all lacked validity when assessing depression in pregnant women. They found that identifying depression in pre or postpartum women was difficult using these scales because the somatic symptoms which occur in depressed individuals occurred *naturally* in pregnant women due to physiological changes. In addition to this, community workers had been

reluctant to use the previous scales because they were time consuming. Cox et al (1987) therefore cleverly designed a screening tool which would a) identify symptoms of PMH problems, and b) could be used by community professionals without the need to have expertise in the field.

The 10-item scaled had been devised through the combination of previous scales, such as the Irritability Depression & Anxiety scale (IDA), the Hospital Anxiety & Depression scale (HAD), and the Anxiety & Depression scale by Bedford & Foulds (1978), along with a few items developed by Cox et al (1987). Each item has a possible score of three, with 0=normal, and 3=extreme/ severe. The highest total score would be 30. A cut of score of between 9-13 is acceptable to identify that a mother is experiencing signs of PND, and this is dependent on culture, language, and personal history (Logsdon et al, 2009; Pallent, 2006).

7.4b Validity of the EPDS (Cox et al, 1987):

The EPDS (Cox et al, 1987) was piloted on 84 mothers living in Edinburgh. Health visitors were asked whether they felt the mothers were normal, depressed or having problems, and authors envisaged that the EPDS (Cox et al, 1987) was able to confirm this. The EPDS (Cox et al, 1987) was carried out in the mother's homes and then placed into sealed in envelopes. The mothers were then interviewed using the Goldberg's Standardised Psychiatric Interview (SPI). To avoid bias, 12 normal women were also administrated. Validation was determined by comparing the scale with the Research Diagnostic Criteria (RDC) which allows diagnoses to be consistent within psychiatric research. The authors concluded that a threshold value of 12/13 was found to identify all of the 21 women with an RDC diagnosis of major depression. The proportion of women above the threshold (n=41) who also met the RDC was 73%. Those scoring about 12/13 were most likely to be suffering from a depressive illness varying in severity.

7.4c Cut-off scores:

Although 12/13 was identified to be the optimum cut-off score, the authors highlighted, and data suggested that 9/10 might also be appropriate cut-off scores for routine workers. Authors advised that a score just below the cut-off point should not be disregarded as this could potentially prevent mothers from receiving the appropriate support. In a systematic review of 37 validation studies, heterogeneity between the studies showed that it was

difficult to create distinct groups for further analysis (Gibson et al, 2009). Furthermore, there was a wide range of values around cut-off scores which were influenced by cultural factors. For example, Vietnamese- Australian was 14/15, Arabic and English 9/10 (Gibson et al, 2009). To determine the most appropriate cut-off score it may be necessary to determine the needs of the population. Although the paper could not identify whether the tool is an accurate screening tool, it is still widely used within many cultures and is a cost-effective way in determining symptoms of PND.

7.4d Quantitative Assessment Tool: EPDS-Lifetime: Meltzer-Brody et al (2013):

The risk of reoccurring PMH issues in later life is increased by 25%, and women with a risk should be carefully monitored. Unfortunately, assessing lifetime PMH issues is not generally obtained at primary healthcare level or within clinical settings. Meltzer-Brody et al's (2013) goal was to produce a screening assessment tool which would be able to identify previously experienced PMH problems at any point in a women's lifetime. Cox et al (1987) had previously reported that women were able to accurately recall any prior episodes of PND, including severity and symptoms. Based on this, the Meltzer-Brody et al (2013) decided to slightly modify the current EPDS scale by asking two screener questions which would focus on women only recalling their worst episode of PND. The screener questions are as followed *"During how many of your pregnancies did you feel sad, miserable or very anxious? By this we mean a period of at least 2 weeks when you were not yourself and which was worse than the normal ups and downs of life.". "After how many of your deliveries, within the first six months postpartum did you feel sad, miserable, or very anxious? By this we mean a period of at least 2 weeks when you were not yourself and which was worse than the normal ups and downs of life"*. The researchers' goal was to assess lifetime prevalence of PMH issues in women with a previous history of PMH problems, and to evaluate the risk factors such as age, education, personality, history of abuse/trauma, anxiety disorders whilst comparing this to healthy controls.

7.4e Results & Internal Consistency of the EPDS-Lifetime:

To assess lifetime prevalence and the reliability of the scale, the authors recruited a large cohort from a multi-site organisation made up of 2981 participants. Participants were a mix of the community, primary healthcare, outpatients of mental health and healthy controls. All participants were administrated the Composite International Diagnostic Interview (CIDI)

(Wittchen, Robins et al, 1991). The EPDS-lifetime scale Meltzer-Brody et al (2013) was also administrated. The inclusion criteria required women to have a presence of a lifetime major depressive disorder (MDD) leaving a sample of 682 women at year four of follow up. Of 682 mothers, 363 (n=2 excluded) screened positive on at least one of the two screener questions. Of the 361 women, 276 had an EPDS score of above 12 indicating symptoms of PostND. The women with symptoms PostND consistently demonstrated a more severe and chronic course of illness than women with MDD outside of the perinatal period. Results also showed that 43% of women with PostND felt that it had developed over pregnancy which helped to identify the onset of it. EPDS scores showed a standard deviation of 6.2, and Cronbach's alpha was 0.82, indicating a good internal consistency.

The EPDS-lifetime had been administrated within three settings representing a large cohort group and indicated good internal reliability. The results were encouraging and could be used in a variety of settings to screen women of reproductive age, and retrospectively. The authors reported that administrating the scale would be valuable in obtaining information from women with an increased risk of developing PMH issues. Along with this, the results indicate that the prenatal period provides a window of opportunity to screen risk factors.

This research used the EPDS-lifetime (Meltzer-Brody et al, 2013) to screen PMH problems retrospectively in birth mothers.

7.4f Qualitative Approach: Thematic Analysis:

Qualitative methods can roughly be divided into two. First, there are those bound to theoretical or epistemological positions in which there are limited variability into how these methods are applied to a framework e.g. conversion analysis ([CA], Hutchby & Wooffitt, 1998), interpretative phenomenological analysis ([IPA] Smith & Osborn, 2003). Grounded theory (Glasser, 1992; Strauss & Corbin, 1998) and narrative analysis ([NA], Murray, 2003) are also bound by broader theoretical frameworks. But there are those methods that are independent of theory and epistemology and therefore have the flexibility to be applied across a wide range of epistemological approaches and theoretical frameworks (Braun & Wilkinson, 2003). Thematic Analysis (TA) firmly sits within the second group of methodologies and is compatible in working with both essentialist and constructivist paradigms (Braun & Wilkinson, 2003). A flexible approach means TA can still provide a rich and detailed account of data without being bound to a framework.

Though IPA is commonly used when experience is at the primacy and when trying to make sense of people's everyday reality in great detail, the goal of thematic analysis is also the same. Grounded theory can also provide plausible theory around a phenomenon (McLeod, 2001) but Braun & Clarke (2006) argue that grounded theory has often been used in a similar way to thematic analysis and the only difference is its theoretical commitment. They argue that researchers do not need to be bound to the theoretical commitments of grounded theory or IPA, as thematic analysis is capable of achieving the same goal. Thematic analysis can be a realist method which can examine experiences, realities, or meanings. It can also be a constructivist method examining how events, experiences or realities effect a range of populations in society. For this research, thematic analysis was used to obtain rich accounts of birth mother experiences around PMH issues and psychosocial risk factors. Braun and Clarke's (2006) 6-step guidelines were followed to analyse data; become familiar with the data, generate initial codes, searching for themes, reviewing themes, defining and naming themes and finally producing the end report.

7.5 Developing research tools:

7.5a EPDS-Lifetime (Meltzer-Brody et al, 2013)

As discussed in section 7.4, the EPDS (1987) tool is a commonly used and validated tool to screen for PMH issues within the UK. Additionally, the EPDS-Lifetime (Meltzer-Brody et al, 2013) is a reliable assessment tool for screening for historical PMH issues (to help gauge recurrent PMH issues). With this in mind and being the only validated assessment tool to measure historical PMH, this study administrated the EPDS-Lifetime (Meltzer-Brody et al, 2013) PMH assessment tool to the participants in order understand the likelihood of PMH issues within this specific group of women.

Prior to administrating the EPDS-Lifetime scale (Meltzer-Brody et al, 2013) to the birth mothers, it had been initially piloted on the BTC staff, and an Acacia team manager. This was to test usability of the scale and to identify any errors or consider making any amendments. For example, the original EPDS-Lifetime scale devised by Meltzer-Brody et al (2003) (see appendix …) asked participants to recall *'how many times have you been pregnant, if none skip to section xxx*'. BTC staff advised to remove the quote *'if none skip to section xxx'*, as all of the birth mothers would have been pregnant at some point. The scale also asked participants *'how many of these live pregnancies resulted in live births. If none of*

these pregnancies resulted in a live birth skip to section xxx'. When speaking with BTC staff, they advised that this question also be removed as this was a follow on from the first question, and all the birth mothers would have had at least one live birth. The Acacia team manager also went through the questionnaire, and advised changes to the formatting so that it would be easier for the birth mothers to complete, i.e., put all the questions in section 1 and 2 into a table format (see appendix A for the final EPDS-Lifetime scale).

7.5b Interview design

The questions within the interview were guided by the data in the quantitative stage, as well as the research aims, as this research adopted a sequential mixed methodology. This was a new study and had not previously been conducted, there were no previous examples of interviews schedules or questions based around the aims and objectives of this research. As an overview, the interview schedule was designed to ask the birth mothers about their existing knowledge of PMH issues, including signs and symptoms, at what point did they experience PMH issues (pre/ post removal), birth mothers coping strategies around the PMH issues, and whether personal and professional support was available to them. The interview also aimed to gain an insight into the personal experiences and the psychosocial risk factors around PMH issues and whether this had an impact on the removal process, and whether signs and symptoms were present in subsequent pregnancies.

There was a process to designing the final interview structure. In the first instance, an initial interview schedule (appendix b) was designed based around general opening questions, questions or topics relating to PMH issues (such as what their general physical and mental health was like prior to pregnancy and after birth, whether they had heard of PND before, any appropriate support or material around PND) and other topics relating to their psychosocial situations, such as at what point did services become involved. The initial interview schedule also considered asking birth mothers about long-term health outcomes and behaviours, for example, coping behaviours following the removal, or the impact PMH issues had on subsequent children.

Once initial interview schedule was designed, it was then checked by the main supervisor. Feedback was then used to make any recommended changes. The 2nd draft of the interview was then given to the Acacia team manager and BTC staff. They too provided their feedback, for example ensuring that I provide accurate information by Acacia on what PND is.. The interview adopted a flexible approach with open ended questions, allowing for

detailed exploration of the birth mothers experiences, but it also served to supplement the information provided within the quantitative tool. A final version of the semi-structured interview schedule was designed (appendix c) based around the 2nd, 3rd, 4th and 5th aims of this research. Each aim helped to devise multiple questions that could be asked or prompted as a guide to the birth mothers.

7.6 Data collection:

7.6a Scoring data

Following both verbal and signed consent on the information sheet, the EPDS-lifetime (Meltzer-Brody et al, 2013) was given to all the women who agreed to take part. This scale consisted of the two screener questions which asked mothers to focus on or recall their worst episode of feeling sad, anxious, low during their perinatal period. Section two of the scale required scoring and followed the same scoring method as the original EPDS (Cox et al, 1987). A score above 12, indicated signs & symptoms of PND, however aall birth mothers were invited to take part in the interview. Reasons behind this included that if a mum scored below 12, this may effect their gateway to treatment. Or it may be possible that she may have lower scores than 12, but an interview may provide more in-depth qualitative data in which she may be experiencing the same level of depression as a person with scores above 12. BTC then contacted the birth mothers to inform them of the next stage. Birth mothers were given the option to contact the lead researcher via a work telephone number, or if they preferred for the lead researcher to contact them to arrange interviews at the After Adoption office.

7.6b Conducting Interviews:

Participants were asked to come to the After Adoption office to conduct the interviews in the counselling rooms. This location was familiar to the birth mothers, and they felt comfortable doing the interviews on the same days as their drop-in sessions. Participants were reminded about the aims of the interview, that they would be recorded using a recording device, and information around confidentiality and their rights to withdraw or pause during the interview. During this time, participants were reminded of their scores on the EPDS-Lifetime scale Meltzer-Brody et al (2013) and were reminded to try and recall their experiences in relation to the scale that had been completed. Information sheets were provided again, and the interviews lasted between 40 minutes to 90 minutes. All

participants were debriefed and were reassured that BTC would support them further if needed.

8.0 Validity and quality of qualitative research

Good quality research should show transparency at each stage of the analytical process (Elliot et al, 1999). Guba & Lincoln (1989) have defined five methods to ensure that qualitative research is of high quality through credibility, transferability, dependability, confirmability and reflexivity.

Credibility establishes whether the findings can be plausible and whether confidence can be placed in the truth of the findings. This can be done through prolonged engagement with the participants of interest, negative case analysis, data triangulation. As well as being a previous staff member of After Adoption and working with birth parents as part of my role, I was aware that the participants for this research were going to be recruited from the BTC programme. Therefore, I ensured that during the data collection phase I remained in close contact with the BTC staff to understand women I would have been interviewing. I visited the site on multiple occasions to have discussions with the BTC staff regarding this research, the process of recruitment and designing the consent forms. I also obtained feedback from the BTC workers on slightly adapting the EPDS-Lifetime (Melzter- Brody et al, 2003) scale so that it was appropriate for the birth mothers. I then attended two drop-in workshops where I was able to meet the birth mothers on the BTC programme. This felt important as it was an opportunity for me to build a working rapport with the birth mothers who were potentially going to be interviewed for stage 2 of this research.

During the process of designing and developing the semi-structured interviews, I ensured that I received peer feedback from professionals working in the field of PMH. I initially obtained viewpoints from management from Acacia Family Support to view the semi-structured interview. It was useful to gain their opinion because they were already aware around what kind of terminology to use within one-to-one counselling sessions with mothers with PostND. For instance, to avoid using perinatal mental health, and to be consistent in using pre/post-natal depression. A staff member from BTC (After Adoption) also looked and provided verbal feedback around the sections in the interview focusing on the removal process or adoption. This was to ensure that again correct terminology was used and questions made sense in relation to the adoption/ removal process. A primary supervisor also was involved around the final template of the interview schedule.

Throughout data collection and until write up of results, I was in close contact with the main supervisor, and Acacia team members, and field notes were kept. These were opportunities for interpretation of results to be compared or discussed to enhance the quality of the results. For instance, through discussions with the main supervisor, and with an Acacia team manager, I was able to analyse a deviant case which has been included within the results of this research. Excluding a case due to its misalignment with the hypothesis or not quite fitting into the emerging themes could suggest researcher bias and skew results. Instead, it is important to explore the case further and seek more information as to why it may feel like an outlier case. This can be done through re-reading transcripts or re-listening to the original interview transcript.

Transferability refers to describing not just the behaviour or the experiences of the participants within the findings, but exploring the contexts of their experiences to add value and creating meaning from it. The qualitative results section does not just describe the transcripts, but also the context within which they were said. Again, this meant re-reading the transcripts, and re-listening to the original audio recordings of the interviews.

Dependability and confirmability suggest that the researcher should be transparent in describing the research steps taken throughout data collection and reporting of the findings, to ensure that the findings are not just a figment of the researcher's imagination but have been derived from data. Green et al (2007) have provided a rigorous and systematic process to ensure that qualitative data is of high quality, especially data analysis methods. These guidelines and recommendations suggest that the researcher needs to immerse themselves in the data by re-reading the interview transcripts and listening to the recordings. This was done at many time points during analysis to ensure high familiarity. Secondly, the process of coding was done in a few different ways. Initially, I re-read all the interview transcripts, highlighted, and annotated them by hand, and then re-read the annotations. Tables were created to extract the highlighted sections of the transcripts and align them to the annotations. This encouraged me as a researcher to begin thinking about coding. A software, NVivo, was then used to transform the annotations into potential codes. The software allowed easy visualisation of codes, and which data extract was under them. The more that was discovered about the topics, or the codes, the more the codes became refined. Following initial coding, the data was revisited to begin to think about how the codes can be linked, or clustered. The final step was to create the themes. A common

mistake is to turn the clustered category into the theme. However Green et al (2007) argue that a theme provides a link between the category and the significance of it. An initial mind map was created to show the connections between the themes, and sub-themes. These were then condensed further and re-named into more meaningful themes where needed. An initial description of the themes was provided to the supervisor who was able to comment and provide any new insights on them. Section 9.0 considers the steps taken to ensure a rigorous and systematic process in the interpretation of the data.

Reflexivity is the process of critical self-reflection and examining one's own lens, preconceptions, biases, and values and how these elements can affect research decisions or the relationship between researcher and participant. As well as conducting literature research, it was important for myself to speak to specific professionals within the perinatal mental health team, and within adoption support to further provide credibility to this research. The process of speaking to professionals within the field of adoption and perinatal service allowed for reflexivity and validated that this research was going to add merit within this field. From the onset of this research, field notes and conversations occurred between professionals and the researcher which helped with the reflexivity process. Section 10.0 reflects on my journey through this research.

9.0 Data Analysis: Reflexive Thematic Analysis

Reflexive thematic analysis begins with a research question and an approach to undertake it. Braun & Clarke (2006) list possible ways to undertake the research from inductive/ deductive reasoning to latent/ semantic level of coding, including understanding a researcher's epistemological perspective (as discussed in section 7.1). Braun, Clarke & Weate (2016) have discussed ways in which a researcher can engage with their data at the coding stage. If a researcher is to engage with the data set at its obvious meanings or expressions and coding is based around these explicitly stated ideas, then this level of coding is referred to as semantic focused coding. The themes with semantic coding are surface level and the analyst would not be looking for anything beyond what the participant has said. On the contrary, latent coding would refer to a researcher coding more implicitly around what has been expressed explicitly. Latent coding would be focused more on the implicit ideas that underpin what is happening explicitly. For this research, I undertook a more latent level of coding which focused on looking beyond surface level meanings and involved interpretative work.

A theme may also be generated inductively or deductively. Inductively developed themes are strongly linked to the data themselves but have less relation to the specific questions asked to the participants. On the other hand, deductively developed themes have been shaped by the researcher's theoretical underpinnings or interests. I took a bottom-up or inductive approach to theme-development, meaning I let the content or the interviews itself guide the theme-development. Themes can be identified by bringing together ideas or experiences whereby alone, they are meaningless.

This section looks further at the phases of reflexive thematic analysis as defined by Braun & Clarke (2006).

9.1 Familiarisation with the data

Interviews were initially listened to get a closer insight to the data when it came to the analysis stage. For each interview, the audio recordings were listened to, transcribed and recordings were then re-heard. At this stage, manual annotations were also made along the right-hand side of printed transcripts page. This included highlighting parts of the transcript which had potential significance or of high interest. Annotating the transcripts in

the first instance, made it easier to find these parts of the dataset for when generating the initial codes.

9.2 Generating initial codes

To begin coding, a table was then created for each transcript (see appendix F) which included extracting elements of the transcripts that were highlighted with potential significance. A qualitative data analysis program, NVivo, was then used to organise this data into manageable and clear codes (see appendix G). After reading and listening through all the audio recordings again, initial codes were typed along the left-hand side of the software tool. Forty-three codes summarising the chunks of data were initially noted. The next process involved opening each interview table and dragging highlighted sections into the appropriate code(s). Once all data transcripts had been worked through, it was clear to view which codes were prominent amongst the interviews, and how many references of data extracts each code contained. The software allowed me to view this readily and arrange the initial codes in order of highest number of references and the number of interviews it was against.

9.3 The stages for searching themes

This phase involved sorting and collating the coded data extracts and forming them into themes (Nowell et al, 2017). Codes were initially clustered together to begin mapping connections between them. Of the 43 initial codes, those that showed overlap or were like each other were clustered together. Smith, Flowers & Larkin (2009) describes this process as a creative one for the analyst, therefore this stage of analysis involved going back and forth, opening each interview, and checking that data extracts were matched to the appropriate codes. The clusters had one central idea or code which would help begin the stage for searching for themes. The qualitative software allowed easy visualisation of data extracts that were allocated to more than one code. For example, one data transcript extract had been coded under ‘childhood experiences’, ‘adoption/ removal process’ and ‘issues towards children’s services’.

9.4 Reviewing themes

The next step was to review the themes. Maguire & Delahunt (2017) have listed questions to consider during this phase; do the themes make sense, does the data support the

themes, if themes overlap, can they be combined, and can sub-themes be formed? Based on this, mind maps were generated for each cluster of codes. The mind maps helped to visualise main topics with its connecting ideas. During this process, it was important to check again that the data transcripts were connected to appropriate codes. The codes then began to form main themes and other codes were renamed into subthemes. Due to the easy visualisation of the mind maps, those that shared similar characteristics or connections could easily be grouped together.

Once all mind maps were created and clustered together, the process of producing a final thematic map then began. It was easy to visualise and consider how some codes combined to create overarching themes, whereas others formed sub-themes. Again, this was another process of clustering those which shared similar connections and another opportunity to review the data extracts. It was possible to also see the relationship or connections between themes. Through this, initial drawings were produced linking themes with sub-themes, and then highlighting the relationships between the main themes. Description of the themes were also produced.

9.5 Defining themes:

In this step the themes were finalised and refined further. Each theme and sub-theme should be expressed in relation to both the data set and the research questions. Patton (1990) says that each theme should be coherent and an internally consistent account of the data which cannot be told by the other themes. The themes should be individuals, but still connect to provide a narrative that is consistent with the dataset. Providing compelling names to the themes is also an important part of the analysis as it is a first-hand indication of what has been captured from the data. Braun & Clarke (2013) encourage short, creative names that capture the reader's attention whilst also communicating the significance of that theme. After a process of going back and forth, and checking in with a supervisor, a final thematic map was shaped consisting of five main themes and sub-themes; Patchy knowledge on PMH, A troubled life, PMH problems present, The agonising grief, Time to change (figure 3, appendix H). These themes (and subthemes) felt significant in their own rights, yet also provided a compelling story for the dataset. All thematic maps can be found in appendix H. Themes are discussed in detail within the results section.

10.0 Reflexivity

I am a 28-year-old, 2nd generation, South Asian, Hindu woman born and raised in a working-class family. As a South Asian woman, and coming from an ancestry of many strong women and a matriarchal family, I initially approached this research naively. Protected by family and elders throughout my much of my life, I was never able to question or approach the subject of mental health with family elders. Additionally, I am not a mother myself, however I had always been aware that entering Motherhood is an extremely sacred part of a woman's life as well as being one of the most profound responsibilities held with great honour within Hinduism. I had always been exposed to many faith-based, and traditional healing practices that were carried out to support the mother's wellbeing, but was curious to question why was this necessarily not being aligned with what was going on within society.

When I began working for After Adoption, I was curious as to why the birth mothers that I was supporting were constantly questionned around their parenting abilities, when often they had no social or familial support, and furthermore were often victims of some level of abuse. Coming from a collectivistic community, and family that went to many lengths to protect Mothering and Motherhood, I found this to be a completely new subject matter which often contradicted my understanding of what Motherhood should 'look like'. I began questioning my own beliefs, but this is when my curiosity was sparked. I wanted to understand the impact removals were having on the mothers, as well as the events leading up to it. More specifically I wanted to explore this in the context of perinatal mental health. Within birth mother assessments, they were all asked whether they had experienced pre or postnatal depression. Through conversations with staff, the majority of birth mothers reported that they had experienced some level of PMH issues, but this was neither explored nor followed up. I felt that this was a gap in practice that should have been explored further. The more I researched, the less I felt I knew.

In respect of this research, I consider myself to be an 'outsider in researcher', meaning that I am not a member of the population recruited. I was fully aware, when embarking on this journey, that I do not have any lived experiences relating to the population of interest. I knew that this could potentially create a barrier in truly stepping into their shoes and fully understanding their experiences. On the other hand, I felt that my curiosity in this research

would allow me to think openly around to what may or may not emerge, and limit researcher bias.

I initially felt that I would readily and easily be able to access the population of interest due to the nature of my workplace, but it became quickly apparent that I had not considered that these participants were not just participants. They were women, they were mothers and they too had real lives. I wanted to give these marginalised women a voice, because I was genuinely interested in how these mothers coped around such a traumatic event, and yet only a very small number of outside organisations specifically supported them. Upon research I found that there were on average 19 adopters support agencies to two independent birth parent support agencies across the UK. After discussions with social work staff within After Adoption, there were no concrete reasons as to why there was such a disparity for birth parent support but this was partly explained by the fact birth parents often had very little trust in professionals. I felt that this needed to be explored further within the interview with regards to birth parent views on professional support.

Over the course of recruitment, I was aware that I could have very minimal numbers from a non-White British ethnicity because I knew that mental health services are not readily accessed by South Asian communities, and that adoption is virtually an unheard subject. This awareness further led into me researching around cultural rearing practices and collectivistic communities. The reality of the research was changing, and I felt that this processes of understanding my own cultural perspective, enhanced my emotional connection towards the mother's experiences. I became more aware through ongoing research and speaking to professionals working within BAME communities (Black, Asian & Minority Ethnic) around mental health and healthcare services designed for these marginalised groups. I became more aware around parental rearing practices within different communities and cultural groups which improved my understanding around mother-child bonding. I started to become more and more involved in a professional world around BAME welfare and was offered a role to support BAME families in Birmingham with PMH issues. However, I wanted to ensure that I did not sway away from the overarching aims and objectives of this research, and that any new knowledge I had come across would open my consciousness around the experiences of these women.

I was aware during recruitment that one of the birth mothers was from a South Asian ethnicity and the same age as me. I felt that there may be more of a personal connection

when interviewing this mother because of our similarities in upbringing and age. I knew that the topic of PMH was a taboo within the South Asian community, but then to be coupled up with the removal of children was virtually unheard of and potentially something of great 'shame' within my community. Prior to the interview I had a discussion with a member of BTC, also of the same ethnicity, and we concluded that South Asians are not a homogenous group, and though there are some similarities, there is so much more diversity than we think. We also discussed that this birth mother will provide an insight into the experiences of non-white British removals, something that lacks in published research. I felt that just by having this discussion with a specialist in this field helped me to become aware of my bias and in turn, reduce it.

During analysis I felt it was difficult for me to move away from being emotive to being analytical. It took a few rounds of listening to interviews and re-reading transcripts for me to really capture emergent and significant themes. I was conscious that I wanted to capture theme(s) that would be across most if not all the data set, but equally I felt it was highly relevant to capture themes which were crucial to the research question whether this be just over a few data sets. Braun & Clarke (2006) have said that a theme captures something important about the data and does not necessarily need to be across all data sets as long as it is driven by the research question. With this in mind, key themes were developed.

There have been instances where I have questioned how my research will add to the ever-expanding area around PMH, and whether having such a small sample size will impede how far this research could potentially go. I have seen first-hand the impact of involuntary removals on birth mothers' lives, the potential for it to transcend generationally, and how there is such minimal space for this specific community of women. Working with Acacia, I have also understood the importance for specialist, tailored projects that support young parents from having their children removed and to de-stigmatise this group of women. I have also actively been in discussions with staff and attended conferences around the impact of child service involvement on a mother's recovery, I now realise the importance of how this research could add to existing training and guidelines around working with birth mothers facing compulsory removals.

11.0 Results Stage 1: Quantitative findings

Section 11.0 will look at the quantitative results and will be followed by section 12.0 which will provide the results of the qualitative stage.

This section will provide the findings from the EPDS-Lifetime (Meltzer-Brody et al, 2013) scale completed by 8 birth mothers. The scale provided important findings that where then later used as part of developing the interview schedule. In effect, the EPDS-Lifetime scale (Meltzer-Brody et al, 2013) was not simply just a screening tool for this research. The results of this section will be in relation the first aim of this research which focused on exploring the likelihood of developing PMH symptoms within this specific group of women. The findings from the scale will also consider the number of pregnancies, the number of removals, the onset of PMH symptoms, the treatment methods, and the demographics such as ethnicity and age.

11.1 EPDS-Lifetime (Meltzer-Brody et al, 2013) mean scores:

The purpose of using the EPDS-Lifetime scale (Meltzer-Brody et al, 2013) was to identify whether birth mothers had retrospectively experienced PMH symptoms, and at what severity were these symptoms experienced. A score of <12 meant the symptoms were mild and therefore within clinical settings, would not necessarily be followed by any specialist. The maximum score on the scale is 30. However, in relation to this research, there was a mean score of 21.6, with SD of 12.7, suggesting that the level of PMH symptoms experienced was severe. Table 1 below provides a breakdown of the scores from each birth parent who completed the EPDS-Lifetime scale (Meltzer- Brody et al, 2013).

Participant no	*Scores on EPDS-L*	*No. of total pregnancies*	*No. of children adopted*	*Onset of PMH symptoms*	*Duration of symptoms*	*Age(s) at the time of symptoms*	*Treatment*	*Ethnicity*	*Stage 2 interviews (pseudonym*
001	26	2	Not stated	1st trimester	More that 6 months	26	Counselling	White British	No
002	22	2 (1 remained in her care)	1	1-3 months postpartum	3-6 months	18	Medication	White British	Yes- Hanna
003	25	4 (incl. 2 miscarriages)	2	1st trimester	More than 6 months	32 & 36	None	White British	Yes- Sarah
004	24	4	2	3 months postpartum	More than 6 months	24 & 25	Medication	White British	No
005	21	5 (incl. 1 terminations, 2 miscarriages, 1 remained with her care)	1	0-4 weeks postpartum	More than 6 months	16	None	White British	Yes- Tina
006	26	1	1	3rd trimester	More than 6 months	29	Counselling & medication	White British	No
007	13	1	1	0-4 weeks postpartum	1-3 months	31	None	White British	Yes- Josie
008	16	3 (1 remained in her care)	2	1st trimester	More than 6 months	22	Counselling & Medication	South Asian: Bengali	Yes- Anisah

Table 1: EPDS-L Scale (Meltzer-Brody et al, 2003) results

11.2 Total number of pregnancies and children removed:

The number of pregnancies differed across birth mothers. Two birth mothers had one pregnancy each, both of which resulted in the child being removed. Two birth mothers had two pregnancies whereby one child remained in the care of birth mother. One birth mother had three pregnancies and had two of her three children removed. Two birth mothers had four pregnancies each, with one birth mother experiencing two miscarriages. These two birth mothers also had two children removed. One birth mother experienced five pregnancies, of which two ended in miscarriages, and one in termination. This birth mother had one child removed, and one remained within her care.

11.3 Onset and duration of PMH symptoms:

The EPDS-Lifetime scale (Meltzer- Brody et al, 2013) required the birth mothers to recall their age, onset and duration of PMH symptoms. Two birth mothers indicated two ages where they felt their symptoms of PMH were prominent and wished to note these on the scale (participant 003 & 004). An average of their ages was taken, 34 and 24.5 respectively. A mean age of participants at the time of their worst symptoms were 25.2, SD of 5.84 and

range 18. The onset of symptoms varied, with four birth mothers experiencing the onset of symptoms during the prenatal stage, and four at postpartum. Despite the variations in the onset of symptoms, the duration of the symptoms showed that all but two birth mothers felt their symptoms lasted longer than six months. Prolonged PMH issues can have a lasting impact on both mother and child and has the potential to turn into more complex mental health issues. It was therefore important to understand whether birth mothers received any treatment or support for these symptoms.

11.4 Treatment methods:

From the sample of eight birth mothers, there were no or varying levels of support and treatment to manage their PMH issues. Two birth mothers were prescribed a combination of medication and counselling, two received just medication, one received only counselling and three birth mothers received no form of treatment. With all mothers scoring above the threshold score of 12, all eight mothers should have received some level of support or treatment. Furthermore, participants 003 and 005 (who received no form of treatment) both experienced traumatic losses through terminations or miscarriages which was stated on the scale. It felt significant to further explore this within the interview stage.

The first aim of this research was to determine the incidence of PMH problems within the birth mothers of compulsory adoptions. Using the EPDS-Lifetime scale (Meltzer-Brody et al, 2013) the scores showed that there was a strong indication that all birth mothers had experienced symptoms of PMH issues with the onset of these symptoms varying. Though it was expected that the incidence level would be high, it was evident from the scores that all birth mothers experienced severe PMH issues with varied levels of support or none. Untreated PMH problems increases the risk of developing postnatal psychosis. The scale also helped to identify how many of the live pregnancies resulted in removals, which was explored further within stage 2 of the interviews.

12.0 Results Stage 2: Qualitative findings

Stage 2 of this research required interviewing those birth mothers who had agreed to be interviewed following stage 1. A total of five birth mothers were interviewed. The interview aimed to answer the following objectives:

- explore existing knowledge and personal experiences around the signs and symptoms of PMH issues, and at what point they were present within this group of birth mothers of adopted children.
- explore existing knowledge and personal experiences around the risk factors of PMH issues and what prevalent risk factors may have increased the likelihood of PMH issues.
- explore whether risk factors or symptoms worsened during the adoption or removal process, and what support, if any, was present.
- understand the journey and experiences of subsequent pregnancies within this group of birth mothers and if symptoms of PMH were present in these subsequent pregnancies/ birth.

This section of the results will discuss five themes that emerged from the analysis, including sub-themes:

Superordinate themes	**Sub-themes**
Patchy knowledge around PMH	
A troubled life	
PMH problems present	PMH issues pre and post removal
	Duty of care to me
	Feeling like a failure
The agonising grief	Breastfeeding whilst in care
	Grieving a child who isn't dead
	Negative behaviours to cope
Time to change: Pregnant again	Motivated for change
	That one professional

Table 2

12.1 Patchy knowledge around PMH:

The first aim of the interview was to investigate the birth mothers' current understanding of PMH issues, and their understanding around the signs and symptoms. The first section of the interview focused on asking birth mothers what they understood by PMH problems; more specifically PND and PNA. The rationale behind these questions helped to also determine whether the birth mothers had been informed about PMH by any health professionals. The researcher was mindful that although they had scored highly on the EPDS-Lifetime scale (Meltzer- Brody et al, 2013), which suggested a higher severity of PMH symptoms, the birth mothers' understanding of PMH problems in its entirety may have been limited. The theme 'Patchy knowledge around PMH' came about as all birth mothers responded with vague responses around what they felt PMH problems presented themselves to be.

For instance, Sarah provided a very literal and brief description of what she understood postnatal depression to be. Sarah was the only birth mother that had reported that she had some form of assessment to measure PND:

S: 'That's my understanding of it, it's just depression. I was, I was tested that I was borderline...erm with my youngest...'

I: 'Ok and do you recall what was used to test your signs and symptoms? '

S: Erm it was just a series of questions'.

When investigating this further she was aware of the signs or symptoms of PND, and she mentioned that she was aware and that she was tested borderline for PND with her first child. This was explored within the interview, and was asked around how she was tested, but again, the response was quite vague. Furthermore, Sarah had indicated on the scale that she had received no support or treatment for PMH problems and although she had been 'tested' borderline, this was not followed up.

Hannah was aware that there was a difference between pre and postnatal depression, however when explored further, there was a lack of understanding of how pre and postnatal depression would present itself:

H: 'Well, I know like pre is like pregnancy and like post is after birth.'

I: 'So, are you aware of some of the signs and symptoms around postnatal depression?'

H: 'Erm well only by what I went through. It was just like I was just crying for no reason.'

When asked if she knew what the signs and symptoms of PND were, Hannah's account was somewhat vague, and went by what she had experienced. She reported that she was crying for no reason, a sign of PMH problems, but was not able to elaborate further.

12.2 A troubled life:

Another aim of this research was to explore the risk factors that may have contributed to the onset of PMH issues and explore the birth mothers' existing knowledge around these risk factors. During the interview, all the birth mothers had been predisposed to many social and emotional disadvantages that may have impacted their parenting and in turn the onset of PMH issues. For instance, many of the birth mothers spoke around issues relating to domestic violence, coercive control, or birth fathers not being physically present to support the women. Other significant relationships were also missing, such as a strong family or social support network, and culturally specific problems were also reported. During the interviews, two mothers had also experienced a background of care suggesting that they had been exposed to a chaotic life during childhood themselves, whilst also describing their relationships with their own mothers, and how this had impacted in some way on their parenting skills. This theme covers the risk factors that came up during the interviews, and the experiences of the birth mothers' troubled lives. All the accounts are prior to children's services becoming involved.

Two mothers had come from backgrounds of care. Hannah and Tina both had experiences of what it was like for social workers to be involved during their own childhood. Hannah did feel that being from a foster care background may have been a risk factor in developing PMH problems. She explained that growing up there may have been difficulties which included her father not being present.

H: 'Erm, I don't know but I think for me it was just because of me being in foster care, like it probably impacted me in that way.'

I: 'So was growing up difficult, potentially? '

H: 'Yeah... Yeah definitely the childhood and possibly the social side as well. Because obviously I only really had my mum and sister. Erm, obviously dad wasn't around....to be honest I never wanted to have kids anyway, so when I did find out I was pregnant, I was kind of, I kind of hid away.'

Absent parents and being in foster care may have shaped Hannah's expectations around parenthood, in turn leading to thoughts around never wanting children. This in itself was a risk factor in developing PMH problems.

Tina was also subject to care and shared an insight into what her childhood may have looked like. She discussed how from a young age, she acted as a primary care giver to her own siblings. The quote also suggests that the lack of presence from her own mother, almost forced Tina to go into early motherhood:

T:' I knew that I could handle my business because I spent a lot of my childhood looking after my siblings because of the way that my mum was.
My family circumstances are still the same, in fact they're non-existent.'

Similarly, Hannah conveys a story that indicates her relationship with her own mother was also complex. Her views of her own mum impacted the way she felt about becoming a parent.

H: 'I'd probably say the anxiety, erm, coz I had this like feeling that I was just going to be like my real mum.'
H: 'So I did kind of like push maybe away a bit, erm, because I just felt like I'm going to be a rubbish mum anyway so, like what's the point ...it was a just a case of you know you feed 'em and put them to sleep because that's all I ever really saw anybody ever doing.'

There was a sense of anxiety around becoming like her own mother, and the more these thoughts came to play, the more it was re-enforced that she would be a bad mother. She also describes what her expectation of motherhood was, which perhaps was shaped by her own childhood experiences.

From the interviewed sample, one birth mother was from South Asian ethnicity. Anisah discussed issues around family abandonment and how this stemmed from having children before marriage. Given her religious and cultural background, this was frowned upon by her family.

A: 'Yeah, because we're Muslim and they were really strict, they didn't want to know me, my family because they said I bought shame to the family and they only cared about what outsiders thought. Because sometimes Asian families they just like to gossip and talk when they hear something they'll make a big thing out it and then they'll carry on talking to other people about it. So my family think I bought shame to them.'

Anisah discussed that she was 18 when she had her first child and had spent a significant amount of time being rejected from her family. During the time of conception of her first, up until present time, Anisah has not had any contact with her family, meaning the family are unaware that she had two subsequent pregnancies.

I:' Hmm, so was this when you got pregnant?
A: Yeah with my first child, so from then they just didn't want to know me and I was only 18 at that time as well and now I'm nearly 24, that's nearly 6 years I've not spoken to my family.'

Anisah discusses the complexity around her social situation because of being isolated and disowned by her family:

A: 'And I was isolated and that really affected me because I had no one to talk to and the only person I had was my kid's dad because I got with him and I stayed with him for so long. He was Muslim as well so and his family were really strict too, because obviously like you can't have babies before marriage but we did.'

She was forced to remain with the birth father despite complications within the relationship and felt that she had nowhere else to go. Due to cultural norms, Anisah was isolated from friends and family leaving her to deal with emotional issues alone, consequently increasing the risk of PMH issues.

A difficult relationship with a partner can increase the likelihood of PMH problems within a general population of mothers. However, within this sample of mothers, there were additional factors, making it particularly difficult for birth mothers to remove themselves from dangerous relationships which ultimately led to the involvement of children's services.

For instance, Tina described the circumstances she was in. Tina had been diagnosed with bipolar disorder, and was under the control of the birth father. In the extract below Tina describes how she was under the illusion that he would change, making it difficult for her to break away from an abusive relationship.

T:' Erm, I think I was living in La La Land if I'm honest, obviously I was with someone who was beating the crap out of me who was a heroin addict, but me being optimistic, I don't know I just was under some illusion that he'd change.'
T: Erm, a lot of it was to do with his dad because obviously being abusive and being a drug addict.'

Sarah also was subject to domestic, cohesive and financial abuse. She describes the chaotic environment she was trying to surviving in prior to removal, whilst also ensuring that she was parenting her children.

S: 'Well I just had constant harassment from my ex and he was coming to my house and threatening to like, I had a couple things from my grandad, and he was threatening to sort of smash them up unless I gave him money so you know in the end erm I was trying to get a restraining order on him but I couldn't because her was never there long enough.'

The struggles and the abuse these birth mothers endured were some of the reasons for children's service involvement in the first place. It raises questions around the lack of professional support or appropriate interventions that could have prevented the removal of their children and may have given birth mothers more positive outcomes. However, as previous information has suggested, fleeing a domestic relationship can often be more dangerous for women (Womens Aid, 2021)

12.3 PMH problems present

This research also aimed to investigate at what point PMH symptoms were present i.e. pre or post involvement from children's services. There are three sub-themes within this theme. The first sub-theme 'Pre and postnatal depressive symptoms present' will discuss the birth mothers accounts around symptoms of pre and postnatal depression or anxiety that they had experienced, prior to children's service involvement. The second sub-theme 'Duty of care to me' captures the birth mothers' feelings of being unheard and a general outlook that there was lack of duty of care towards them from health professionals. After the involvement of children's services, birth mothers felt that the lack of support from professionals worsened their mental health and parenting practices. The theme 'Judged around parenting' describes these feelings. Feelings of judgment and guilt are indicators of PMH problems.

12.3a Pre and postnatal depressive symptoms present:

Birth mothers showed indications of pre or postnatal depression and/or anxiety signs and symptoms prior to children's services becoming involved.

Hannah was the only birth mother who had experienced *pre-natal depression* i.e. during her pregnancy. During the interview, Hannah mentioned that this was the first time she was openly speaking about her PMH issues. Some pre-natal depression symptoms can be characterised by the inability to bond with the baby, and more severe symptoms may include the desire to lose the unborn baby or harm to self or to unborn baby. Hannah spoke around the intrusive, and what she described as 'evil', thoughts about her unborn child.

> *H:' ...like all through my pregnancy I really did think some nasty things. There was points when I'd think, why don't this baby just die inside me because I really didn't want kids.'*

Hannah describes her account of not physically or emotionally connecting with the unborn baby, and not feeling any movements of the baby whilst she was pregnant. Often an emotional disconnect can lead to a physical disconnect (Dresdon, 2020), which can perhaps explain Hannah's experiences.

H: 'I mean to be honest, even when I was pregnant, I didn't even feel her moving. I used to tell the midwife that I had because by the time I had I admitted that I hadn't, she sent me to hospital and there was no way I was going in hospital, so I used to lie at every visit. I used to be like "oh yeah she's moving loads", and I hadn't felt it move once. So whether that was me just blocking out the fact that the baby is actually there, I don't know.'

In Sarah's case, she displayed signs and symptoms of *postnatal anxiety* before children's services became involved. She discussed the extent of her worries and anxieties around something happening to her child or losing her, and as a result she would constantly check that she was breathing around the bedside. Sarah mentioned that she was assessed around her postnatal depression:

S:' I don't know, I mean with Kate I mean I mean I was excited but, my erm thoughts were I was just always worried that something was going to be wrong with her, I was just always worried about that. So I remember that about Kate, just constant worry and anxiety. Erm...erm... and afterwards, erm I was always just worried about losing her, and in the end and early days I was just worried that she wa-, I'd just sit by the bed all day and night long just watching her, making sure she was breathing even though I had got like a pretty high-tech baby monitor.'

As literature shows in this area, it is possible that these symptoms experienced prior to children' services involvement stemmed from disadvantageous social risk factors; such as difficult upbringings and violent partner involvement. If appropriate professional support was provided to birth mothers around the social and psychological risk factors they were experiencing, this may have reduced or eradicated PMH issues.

12.3b Duty of care to me:

There were strong beliefs amongst some of the birth mothers to suggest that they did not feel that they were adequately supported professionally, prior to the adoption and post adoption. This subtheme captures missed opportunities where health and other professionals could have intervened or supported birth mother adequately to improve their situations socially and emotionally.

Tina stated that she was left to survive on her own following the removal, even though she was16 years old.

T: 'I didn't even get a chance to go to court in the end to say that they've left me homeless, that they'd left me in danger, that he was 19 years of age and I was a child, where was social services duty of care to me.'

Tina understood that if she was better equipped and supported by the professionals involved, this could have significantly improved many psycho-social aspects of her life. She emphasised that support was focused around her son, Liam (first child- pseudonym), but there was a lack of consideration from professionals looking into her situation.

T:' like they wasn't interested in what was going on with me, it was always about Liam, Liam, Liam. There was no thought that oh if we help mum and support mum maybe it would be better for their future.'

Anisah also lacked all social support, and therefore relied on professional support. However, similar to Tina, she also displayed an account whereby emphasis around support was generally for the wellbeing of the child, not the mother.

A:' I was, but at the same time I felt like I wasn't, it was like they were against me instead of helping me at the same time, and as soon as I got my solicitor it was like that's it they just didn't want to speak to me and they just wanted to remove the children and have something against me.'

Anisah had been referred to a postnatal depression charity following the birth of her third child. Her current social worker had referred her on for support and Anisah did emphasise the importance of professional support.

A: 'Yeah I can imagine. Was anyone supporting you sort of during the adoption process or did you know what was going on? A: None whatsoever. Like I didn't have a clue about anything like as much as I know now and I wish they'd told me about all these things, like even like referring to Acacia, but I'd never been told about anything like that.'

Sarah provided an emotional account around how she felt she was treated. Despite social workers being aware of her current situation, she lacked both personal and professional support during the process and after adoption. This resulted in extreme measures of coping such as self-harm and alcohol use.

S: 'I just think the worst bit for me was when they came and took the children off me and they just left me with nobody. That was the time when I needed somebody. You know that was the time that I just ended up getting really drunk trying to, I mean I cut myself and then I was trying to commit suicide and then I was taken under mental health team.'

After the removal of her children, Sarah felt that she had nowhere to even live. She describes that her only option was to move back in with the birth father despite him being a large risk factor around the removal. Sarah emphasised that she would have benefited from support.

S: 'You know my children had been taken and I'd become homeless. You know I couldn't speak to my mum and I had no body, and that was when I needed some help.
... And then like the year after I had to sort of move in with my ex who'd you know, you know got my children removed, I had to then go and live with him because I had nowhere to live.'

In addition to the lack of wider social and familial support that all the birth mothers faced, they felt that they were also hugely let down in a professional capacity too. This sub-theme captures the injustices felt by birth mothers both pre and post removal, and the lack of trust they developed with health professionals, who could have supported them out of many crisis points.

12.3c Feeling like a failure:

Some birth mothers described the scrutiny they experienced around their parenting during the involvement of children's services.

For instance, Tina discussed how she already felt failed before she even had the opportunity to prove that she could parent adequately. There were feelings of judgement

due to the background of care she had come from. This may have been a large factor explaining why Tina experienced frustration and anger towards professionals.

T: 'I mean I was under so much scrutiny when I was at that mother and baby assessment centre, and I always say this, sometimes I don't, like they, basically they've already failed you before you've even had an opportunity when you've come from such a background.'

Anisah also faced similar experiences. Whilst children's services were involved, but the children were still in Anisah's care, she was provided shelter at a refuge. She describes being watched by social workers, relating them to a CCTV camera.

A: 'Yeah. Yeah I just felt like I was being watched 24 hours like I had no life and couldn't do anything
apart from being just stuck inside so they can't say that I am doing anything.'

Despite describing her honesty around where she was, there was still an element of being judged and monitored. Social workers would check up on her and call the refuge to see where she had been.

A:. 'But it was like they were CCTV like social services they would, they used to call the refuge to see if I had been anywhere at the weekend and to check the camera every Monday to see if I had stayed away every weekend and that's how bad it was'

There was a strong lack of trust between Anisah and social workers which further perpetuated her depression. The lack of trust and feelings of scrutiny with health professionals led to anger, frustration and birth mothers feeling like failures. A stronger relationship with health professionals could have reduced these feelings and lowered the risk and severity of PMH problems.

12.4 The agonising grief:

This theme captures the birth mother's experiences following the removal of the children, from the moment of placing them into temporary foster care to adoption placements. There are three sub-themes. All of the mothers' accounts around losing their children to

adoption were described as an unbearable process. There was also a lot of uncertainty and frustration following the adoption in terms of their rights around letterbox contact. Letterbox arrangements are not a legal requirement, but a mutual agreement between birth parents and adopters. The birth mothers would often be waiting to hear from the adopters (via letterbox contact), but instead would be faced with much disappointment. The sub-theme 'Grieving a child who isn't dead' captures this. Two of the birth mothers discussed the issues around abruptly stopping breastfeeding, with one discussing her extreme sadness and guilt when she heard care services provided a donor's breastmilk to her baby, and the sub-theme 'Breastfeeding whilst in care' discusses this. To cope with the removal, some engaged in negative health behaviours, such as relapsing into alcohol and drug use, going back to an abusive relationship, or repeating the cycle of pregnancy again to replace loss.

12.4a Grieving a child who isn't dead

Three of the birth mothers described the removal process as similar to that of grieving a loss of a child. The involuntary removal lead to feelings of complicated grief, sadness, anger and confusion.

Tina's account below emphasises the uncertainty of not being in the know.

T: 'could never have another child adopted and...I just couldn't, it's a lot. It's like grieving someone that isn't even dead, and just not knowing what's going on'.

Anisah describes the feeling of being numb when she heard that the final decision will be adoption. From her interview, and the extracts in the themes, Anisah describes her feelings of loneliness and being left to deal with the adoption process without any social support. Anisah discussed the importance of her trying to remain positive in order to prevent self-harm, and maintained the hope that they would one day return back to her care.

A: 'Because it was through court, when they mentioned it in court it just hit me. I felt like I was just dead, that's what I was feeling. But I was really trying to think positive at the same time because my children were so young and I know they will come back one day. Even

there is so long to wait, they will come back. These were the things that I was just saying just to stop myself from doing anything stupid'.

Anisah's quote below suggests the level of grief she was experiencing similar to that of a bereaved person. She also describes her final goodbye session at the contact centre.

A: 'Like so much yeah. And like I always used to cry day and night, even the last contact I had, I was crying at the contact and everybody was just looking at me. I had really bad well my depression went so much worse'.

Sarah discusses her concerns around letterbox contact not being a legally binding agreement and its impact on birth parents. Sarah's account provides and insight as to how important receiving information around her child is, as it is the only piece of information around her children she can hold onto.

S:' ... you know this thing around letterbox I wish was a contract that they could just sign in court, because it's not legally binding, and that is the one thing, that...I just don't know, I don't know. I just don't know if I will get a letter, well I have been told I will so I have to try and remain positive but I've heard of a couple of people, not that I know that many people from BTC but they haven't had their letters and you know, I just think something needs to be done about it because we don't have much left...we've been stripped'.

S'... we've been stripped that just that little definite, definite peace of mind of having a letter erm as an agreement as part of the adoption in court is agreed, then I think that would be better because then you would know for definite. I'm just sat waiting, you know they don't have to write, and I hope to god they do [cries]'.

There was definite grief experienced by each of the birth mothers and sense they were forced into re-evaluating their identity, as their title of a mother was forcibly stripped away. Again, the accounts raise questions as to how much emotional and practical support was offered to the birth parents to deal with this removal as the accounts captured the level of uncertainty about their identity, where to seek support, and what to do next.

12.4b Breastfeeding whilst in care

Two birth mothers breastfed their children during the care proceedings. Anisah described that the breastfeeding process involves close proximity, and for her this was the greatest feeling. However, for both birth mothers, there was an abrupt ending.

It was clear to understand that Anisah found it a difficult process to stop breastfeeding after her son was removed. It impacted her mental health as she describes that she may have done something 'stupid', i.e. self-harm, due to her identity of being a mother being stripped away. There were also consequences physically as her body was forced to go through changes.

A:'I'm just so surprised that I've come this far and I'm here, because I could have ended up doing something stupid. So yeah it was really horrible when I had to stop breastfeeding. Like the most natural thing for a mum to do, and I couldn't even do that. Like my body was going through changes too, like it was hard'.

Anisah goes on to discuss that she continued to produce milk following the removal as a result her providing milk whilst her son was in her care. The stopping of breastfeeding did however impact her wellbeing both physically and emotionally.

I: 'How did it affect you physically?'
A:' I think because your still producing milk, and then almost all of a sudden you have to stop, so it was just hard to do that. And yeah, I was just feeling low and feeling sick all the time'.

Sarah also breastfed her son, however her situation required expressing milk at home, and then travelling to the hospital where he would be fed as he was a premature baby. She was advised by clinicians to provide breastmilk as this would provide the best kind of nutrients for her son. On one occasion Sarah recalls being told that she was not at the hospital enough.

S:' I was trying to express milk which would take up a lot of time. Erm and then I would have to take it to the hospital, and then the social were saying 'oh that you're not giving enough

time, you're not at the hospital enough', but then I had my daughter as well so it was quite difficult to try and just do the right thing at the time'.

At the time Sarah was breastfeeding, she also suffered with a relapse in her drinking. In the extract below she gives an account of an episode where she went off on a binge drink. She describes being advised by health professionals within the hospital that they did not want her milk as it would be contaminated.

S':... because I'll be honest with you even though I don't want to, I was providing milk for him and for a certain amount of time, erm and then I just, I just went off on a binge of drinking [sighs] so then they said 'we don't want your milk because it might be contaminated' and and then they were talking about him going into foster care for a little while'.

Whilst explaining that a breast donors breast milk was used, Sarah became emotional during the interview as she was forced to re-visit this memory. Again like Anisah, when this natural process was abruptly stopped, she perhaps could have questioned her identity as a mother.

S'... the only thing that I would get upset with is obviously I had this binge, which was you know stupid, but 72 hours everything would have been out of my system but then they just decided to use somebody else's breast milk, some donors breastmilk but [sighs]... but that's in hindsight really you know. It didn't feel nice'.

Both Anisah and Sarah were single mothers with young children, with a history of domestic violence, homelessness, and had the involvement of children's services. They described feelings of isolation contributing to a relapse in alcohol and drug use, or thoughts around self-harm behaviours. Multi-agency working with adequate emotional and practical support for both birth mothers may have prevented or minimised these negative coping behaviours. There was a lack of provision to support the birth mothers around the implications of a sudden end to breastfeeding.

12.4c Negative behaviours to cope:

Following the removal, some of the mothers engaged or continued on the path of negative health behaviours. These behaviours included, alcohol and drug use, poor self-care and thoughts and actions around self-harm.

Hannah was a young parent who admits that she went out of control following the removal of her child. As a way to cope she engaged in drinking behaviours, drugs and sex.

H: 'Erm... (sighs) I think I went a bit of out of control, like I just started binge drinking'.
I: 'As a coping mechanism'
H: 'Yeah, I started binge drinking, I dabbled with certain drugs, and erm, like I was sleeping around as well'.

She also discussed that on occasions, the outcomes around the adoption would trigger her emotions when she has had a drink.

H: 'Erm, I don't know to be honest, because it wasn't like I would just think about it and go out drinking. But then it was hard because sometime I would be fine when I have a drink, but then other times I'd sit there and cry about the adoption and stuff'.

Anisah had concerns around self-harming behaviours. On a few occasions she mentioned that she had thoughts around self-harming but always would refrain because of the hope and possibility of having her children back in her care.

A:'... like if I went back to the refuge I was feeling like I was going to self-harm but I was trying my best not to because I had a chance to get them'.

The removal had an impact on Anisah's mental well-being and mood and in turn her eating and self-care habits. For instance, she took no interest in her appearance, which she previously would have.

A:' When I was hungry wanted to eat I would feel sick looking at food, so then I wouldn't eat. It was just like this weird cycle, and I was just weak. I used to just walk around with no make-up like a tramp and everyone would just know that I was going through something'.

As a way to deal with the removal of her children, Sarah resorted to alcohol misuse and self-harm. Sarah also attempted suicide and as a result was taken under the care of a mental health team.

S: 'I just think the worst bit for me was when they came and took the children off me and they just left me with nobody. That was the time when I needed somebody. You know that was the time that I just ended up getting really drunk trying to, I mean I cut myself and then I was trying to commit suicide and then I was taken under mental health team'.

Though these were generally negative coping strategies, the only statutory support they could receive, post removal, would be from the same local authority who removed their children in the first place. With the lack of support and trust prior, during and post removal from agency professionals, birth mothers resorted to dealing with losing their child in negative ways.

12.5 Time to Change: Pregnant again:

Of the three mothers who did get pregnant again following the removal, all were successfully able to keep their children within their care. A dominant reason for this was down to their motivation to ensure history would not repeat itself. Another key reason was that professionals during the subsequent pregnancy were much more supportive and listened to the needs of the birth mothers. They were able to build trusting relationships with key professionals who helped the child remain in the birth mother's care. Two sub-themes will be discussed within this section focusing on 'Motivated to make a change' and 'That one professional'.

12.5a Motivated for change:

Hannah describes the emotional turmoil she was faced with when she found out that she was pregnant again. She expressed that she did not want another child to be removed from her care and this was a positive motivating factor for her to make changes in her life. She acknowledged that social services will once again be involved. Hannah seemed to be more aware and familiar around the process the second time round.

H: 'Erm, it was a worry, I really had to think about what I was going to do. I didn't know whether to terminate or to carry on'.

I: 'Do you think that was because of your previous situation?'

H: 'Yep, I think the thing was more, well do I carry on with this pregnancy, and I knew social services was going to be involved anyway, I just knew. So I didn't go into it blind. Yeah I did really consider a termination, because I didn't want to be put in that situation again. I didn't want to give birth to another child and they take It'.

Due to Hannah's previous experiences, she did carry some sense of worry and anxiety throughout the pregnancy around what the outcome may be. However, she had a lot more motivation to keep this child within her care and emphasised that she wanted to fight for this and would not let anyone get in her way of taking her child from her. Her motive was to prove to social services that she will not let her history repeat itself.

H:. 'And I definitely had more motivation and that just came from a case of social services being involved. I just thought nah, I'm going to fight you and I'm keeping this one. I'm having this one and you're not taking it. I had a lot more fight in me'.

Tina also expressed her concerns when she found out that she was pregnant with her second son. She had already terminated two children based on her anxieties around children's services being involved and her relationship with her partner, however continued to replace that loss through a subsequent pregnancy. In the extract below she describes the process of becoming educated around her conditions and becoming self-aware.

T: 'Erm, absolutely petrified, I'd already had 2 abortions which absolutely ruined mine and Harry's relationship... I was still suffering with clinical depression'.

When she did find out that she was pregnant again, she was extremely motivated, similar to Hannah, to prove to social services that they will not remove another child from her care.

T: 'Ok yeah I had this mindset that I weren't going to be, I basically promised myself that I would never be a vessel to having children for social services'.

Eventually, Tina was able to break away from this relationship, which again was another turning point in her being able to keep her second son in her care.

T: 'Erm the only thing that I was anxious about was Harry, because he was becoming more controlling and aggressive and I was so relieved that I had my proof that he'd been cheating. And for me that was the turning point and I was so glad that he was out of the equation'.

Anisah fell pregnant with her third child with the same birth father. However, this time, she had left the relationship with the birth father and was frightened by the thought of social services removing her third child. This fear was her motivating factor.

I:' Hmm and do you think that made you more motivated to keep or fight this time?
A: Yeah, and I think because of the past you learn from it and you know what you're expecting, and like If I do anything stupid- and I know the feeling so I wouldn't even do anything but do what they tell me'.

Though the birth mothers were pregnant again and were motivated to make a change, there were definite feelings of anxiety during pregnancy. However, it seemed that social circumstances had changed, and adequate support was put in place which helped birth mothers to cope better and prevent severe PMH issues.

12.5b That one professional:

Hannah, Tina and Anisah all emphasised the importance of having key professional(s) involved that can support them both practically and emotionally. This played a significant role in their emotional wellbeing during the pregnancy and whilst children's services were involved, and most importantly their positions to keep their child in their care.

Hannah discussed that both of her pregnancies were very different in terms of the professionals involved. During her second pregnancy, Hannah received adequate support from the social worker who she described to be doing a lot of work 'behind the scenes' to support Hannah in keeping her second child.

H: 'Yeah because, all through my pregnancy, I was like "am I keeping it, am I keeping it, am I keeping it?" and she never gave me an answer, even right until the very end, she wouldn't give me an answer and I found out why that was. It was because her managers wanted to go straight for an adoption, and she was like give her a chance, and she was literally fighting her managers to give me a chance'.

Hannah described the second social worker as being more people centred as opposed to 'ticking boxes' and able to develop a healthy relationship with Hannah. Hannah discussed that the type of professionals involved plays an important part in helping birth families feel supported and valued and ultimately keeping their children in their care.

H: 'Erm I just think both experiences were different, and the social worker with my daughter, I think she was just tick boxing, but the 2nd one with Tom, I don't know she was a bit more people centered. Like obviously she has to tick the boxes...'
I: 'But she was taking into account your story'.
H:' Yeah, so like I think also played a part because she was involved from when I was pregnant with my son, so...yeah consistent'.

Tina also highlighted the importance of the one health professional who she describes as her guardian angel, to support her to keep her child within her care, despite Tina's history.

T: 'I had a specialist erm consultant who deals with women with mental health problems, and thank god Puja that she was just, she was my guardian angel'.

Anisah reflected on what her life could have been like had she had received adequate support from professionals. She discussed the issues between different local authorities and the inconsistency in support. Again for Anisah, there was one particular social worker who was integral in assisting to keep her third child within her care.

A: 'Yeah support now, but I wish I got all this before, like the children's services from Walsall weren't even that helpful because now I can see the difference from Birmingham to Walsall, and the social worker that I have now he's like he's really good'.

Anisah was the only birth mother who at the time of the interview was receiving specific support around postnatal depression and this was having a positive impact on her wellbeing. She wished that this support could have been provided when she had her first two children and perhaps the outcomes could have been very different.

A: 'Erm the social worker he was helpful, and the midwife that referred me to Acacia, so that was like, I was actually like pleased, like thinking that they had referred me because I'd never had that before. This just feels like something new, like because I'd been through so much I just wish I had the support before, otherwise and it would have made a big difference because I probably would have had my children with me now'.

There was a clear distinction around the level and quality of support received by these birth mothers who went on to have future pregnancies. Circumstances and times had changed, and its highly likely that the level of training and awareness in health and social care work had increased, and allowed the birth mothers to build trusting relationships with professionals (which was previously lacking).

In summary, the themes and sub-themes provide an insight into some of the experiences that the birth mothers faced prior to the removals and post removal. All birth mothers, prior to involvement of children's services, lived a socially disadvantageous lifestyle with experiences of domestic abuse, drug and alcohol use, previous mental health difficulties, cultural differences around motherhood, and lacked robust social and professional support. All of these were risk factors which increased the likelihood of developing PMH complications. However, amongst all the birth mothers, there was a unanimous feeling that there was a lack of care from professionals which perpetuated and worsened their symptoms, prior, during and post removal. The grief experienced by birth mothers when their children were removed, and the lack of or no support from agencies, can explain the negative coping behaviours. However, the results also emphasise that the quality of care and trust received by professionals, even if it is just by one, can have the ability to change a birth mother's life. This can be supported by the three birth mothers who did have subsequent children, and successfully kept them within their care with the help of supportive professionals.

13.0 Discussion

This chapter will discuss the findings of both stages 1 and 2 in the context of the aims of this research, and existing or new literature. The purpose of this research was to explore the incidence of PMH issues and investigate the psychosocial risk factors of developing PMH issues in a sample of birth mothers who had experienced compulsory adoptions. Birth mothers facing compulsory removals and adoption are often forgotten within the adoption triad and this is a novel piece of research in this area. To date, no such research has explored psychosocial risk factors around the development of PMH within birth mothers of *compulsory* adopted children.

Stage 1 (13.1) will discuss the findings that focused more closely at recording the historical symptomology of PMH in the birth mothers, using the EPDS-Lifetime scale (Meltzer-Brody et al, 2013). More specifically this sub-section will concentrate on the severity of the symptoms based on the scores that were obtained, the length of these symptoms and whether support was offered or not. The findings for stage 1 will be linked with existing literature.

Stage 2 (13.2) allowed for more in-depth data to be obtained during the interviews in relation to the birth mothers experiences around removal and PMH issues. Stage 2 of this section will therefore discuss more specifically the unseen PMH issues and inconsistency in screening procedures, the risk factors around PMH issues, the complex grief and psychosocial crisis birth mothers faced, but also the importance of how appropriate professional support enabled birth mothers to keep subsequent children within their care.

13.1 Stage 1:

Stage 1 of this research aimed to investigate the prevalence of PMH issues within a group of birth mothers of compulsory removals from a post-adoption agency, through a quantitative approach.

13.1a Severe, prolonged symptomology of PMH issues:

A key part of this research was to ensure, that despite the scores, all birth mothers would have been contacted to take part in the follow up interviews to draw upon comparisons between those who scored low and those who scored high. The mean score of all the birth mothers came to 21.6, consequently meaning the severity of the symptoms were high. To date, no research has explicitly investigated the severity of PMH symptoms in birth mothers of compulsory removals and severity of PMH symptoms were high within this cohort. However Broadhurst & Mason (2019) did find in 72 birth mothers that the prevalence of severe mental health issues prior to removal were around 83%, and exacerbated rapidly after removal. The study suggests that mental health issues are highly prevalent and often severe amongst birth mothers. Furthermore, in a comparative study, researchers found PMH symptoms amongst adoptive mothers ranged from mild to moderate with some severe cases, and furthermore, depressive symptoms decreased with marital status, and higher socioeconomic status (Senecky et al, 2009). Though there is no published research around the severity of symptoms of PMH in birth mothers compared to a general population of mothers or adoptive mothers, birth mother characteristics such as low socio-economic status, social adversity and a lack of social and professional support (Chance4change, 2015; Broadhurst & Mason, 2019), strongly suggests that they are at a higher risk and severity of developing PMH issues. A limitation of the EPDS-Lifetime scale (Meltzer-Brody et al, 2013) meant that the birth mothers were not able to clarify exactly how long they felt their symptoms persisted, but what could be deciphered was that prolonged, untreated PMH symptoms has the potential to turn into more complex mental health issues such as perinatal psychosis, and can perpetuate into later life (Maternal Mental Health Alliance, 2020).

With all but two birth mothers stating that the symptoms went on for longer than six months, this also suggested birth mothers should have been offered treatment, counselling or follow-ups at the time of these symptoms. In terms of treatment or support, again this varied with all birth mothers, however three mothers did not receive any form of support or treatment, further validating that PMH screening within primary care services may be inconsistent. Two mothers who received no treatment whatsoever (Sarah and Tina), also experienced losses in different forms through miscarriages and terminations. The loss of children through these means can be a significant life stressor with the potential to contribute towards PMH issues. It could therefore be argued that these women were at a

higher risk of experiencing PMH problems. Kinsey et al (2015) found that women with a history of miscarriages, may be more vulnerable to depression during the first month postpartum, and this is a potential risk factor that increases the risk of PMH issues which should be taken into account during screening procedures. Though research around abortions and PMH problems are scarce (Giannandrea et al, 2013), Reardon (2018) highlighted that there is a general acknowledgment that termination through abortion is consistently associated with existing mental health issues and in turn worsened mental health problems after termination, compared to women without a history of abortion. With regards to Tina and Sarah, the absence of treatment and support could have led to considerable psychological consequences.

Previous research has unfortunately demonstrated that it is not uncommon for birth mothers to experience a repeated cycle of removals and as Broadhurst et al (2015) has pointed out, repeated removals within a family system can often be seen as routine because, put simply, the birth mothers have not been given enough time to demonstrate positive change in their life. This was the case for three birth mothers entering a repeated cycle of compulsory removals and was later discussed within the interview. Another significant finding was that both Anisah & Sarah, two birth mothers that entered repeated proceedings, also experienced their onset of PMH issues within the first trimester of their second child. It can be assumed that PMH problems within the first trimester of the subsequent pregnancies, resulted from the psychological trauma of losing a child to adoption, and negative life circumstances. This can be supported by Broadhurst et al's (2014) research that the trauma of losing one's own child to adoption can be ongoing into subsequent pregnancies. Anisah's and Sarah's experiences reinforce the need for appropriate screening for PMH issues, which can help interventions and support to be offered at the earliest convenience.

13.2 Stage 2:

The second research question was to explore the prevalent psychosocial risk factors that birth mothers experience in relation to developing PMH issues. This section will examine these themes further, whilst referring to existing literature and the research questions.

13.2a The unseen PMH symptoms & inconsistency in screening:

From the interviews, it became evident that some of the birth mothers were experiencing PMH symptoms prior to the involvement of children's services. Though this was a small sample size, two birth mothers shared some of the signs and struggles around PMH symptoms prior to the removal of their children. For instance, it emerged that Hannah had experienced intrusive thoughts about the unborn child. These thoughts included wishing a natural termination of the pregnancy. Intrusive thoughts about harming oneself or the child, is a worrying experience for a mother going through pre or postnatal depression (NHS, 2017; Baby Center, 2017). However, if these symptoms are left untreated, there is a possibility of debilitating mental health issues. There were also signs that she could not emotionally bond with her unborn child. An inability to bond during pregnancy can be a sign of prenatal depression whereby the risks are increased if the pregnancy is unwanted. Hannah also concealed these thoughts to professionals. This supports existing knowledge that younger mothers may experience low self-esteem, unwanted pregnancies, and are less likely to share their worries (Mental Health Foundation, 2013; Public Health England, 2018). Sarah discussed that following the birth of her child, she would face constant worries about her baby, and would spend a significant amount of time ensuring that the baby was breathing. These signs fit in line with descriptions from Anxiety UK (2018) whereby a new mother may experience postnatal health anxiety (being preoccupied that something is wrong with the baby). Being informed as having 'borderline' PMH problems, there was a possibility Sarah would have missed out on receiving adequate support to manage the anxiety and perhaps fallen through the gaps of professional support.

Though these were historical removals and practice may have been adapted over the years, there is still some suggestion that routine checks around PMH are still uncommon. For instance, in the UK, the NICE guidelines suggest healthcare providers screen for PMH issues if symptoms are suspected through clinical judgment. The guidelines do not recommend providing an assessment to all mothers, or mothers-to-be (Levis et al, 2020). However, in a Norwegian thematic analysis with public health nurses, all agreed that routine and mandatory screening with the EPDS (Cox et al, 1987) tool was more beneficial and less invasive in bringing up the subject of mental health with mothers (Langvik, Haberg & Storholt, 2020). Given that all the birth mothers were all at higher risk of developing PMH issues due to their age during conception, a lack of interpersonal relationships, and other psychosocial disadvantages, there were inconsistencies in screening for PMH symptoms (as outlined in stage 1 of data collection). These inconsistencies in screening fit in line with

previous literature. Nimalathan (2011) discussed that during the perinatal period, it is routine practice to ensure mothers are screened for physical complications such as gestational diabetes and hypertension, and though the rate of PMH issues is higher (10-15%), there is no robust screening procedures to measure symptomology within primary care and community care settings. With more awareness around PMH within community and primary care settings, women may be more confident in seeking support, understanding what support they are entitled to, reducing adverse outcomes, and potentially decreasing the chances of compulsory removals. The original EPDS scale (Cox et al, 1987) is supposedly still used to help health professionals to identify mothers displaying signs and symptoms of PND (Meltzer-Brody et al, 2013). However, in a systematic review by Hewitt (2009) it was found that in fact less than 50% of cases of PND are actually screened in a primary care setting or within routine clinical settings. There are considerable consequences on not just the mother, but also the partner and the long-term emotional development of a child. Given the adverse effects of PMH, Meltzer-Brody et al (2013) claimed that lifetime PND should be an essential component of the medical history of any women of a reproductive age. Unfortunately, this is again rarely done despite evidence suggesting that there is an increased risk by 25% of recurrent PND (Meltzer-Brody et al, 2013).

13.2b The unique psychosocial risk factors:

As previous research has pointed out, the majority of removals within the UK stem from cases of child neglect and abuse by the parent (NSPCC, 2017). This research highlighted that all the reasons for removals stemmed from preventable psycho-social problems. Literature has consistently found that partner support and healthy relationships with other family members and peers, can be a protective barrier against developing postnatal depression (Milgrom et al, 2008; Beck, 2001; Broadhurst & Mason, 2019). Yet, domestic partner violence or risky relationships or no partner support was prevalent amongst all birth mothers, which has been supported by the findings of the Pause Project (2020). Research has also pointed out that a woman subject to abuse will be at higher risk of perinatal suicide ideation (Alhusen, Frohman & Purcell, 2015) Therefore, questions arise as to whether these women were already at higher risk of developing severe PMH problems, pre children's services involvement, compared to a normal population of mothers. For some, violence in the relationship was the main reason for children's services to become involved in the first place due to risk of harm to the child. This also supports the findings by

NSPCC (2016) where domestic violence was a significant contributor towards cases of children in need. However, one of the significant reasons as to why women may not leave is because it can be particularly dangerous, with around 55% of women killed by their partner within the first months of separation (Femicide Census, 2018).

Having a supportive upbringing by family and society has consistently shown to be a protective factor against developing PMH complications (Broadhurst et al, 2017; Broadhurst & Harwin, 2018; Beck, 2001). But as research has pointed out, birth mothers have often themselves been caught in the child protection system and have almost certainly experienced difficult childhoods. Both Tina & Hannah, grew up in a background of care, where a strong family structure was lacking. Therefore, this would have been a strong indicator to suggest that the likelihood of PMH issues would have been higher, compared to a normal population of mothers. In line with findings from Broadhurst & Harwin (2018) 40% of birth mothers (total sample, n=11000), were in their teenage years and had been subject to some level of care themselves, which supports both Tina and Hannah's experiences. Both Tina and Hannah commented that with the right support, they would have been able to parent their child appropriately.

To further support the impact of the absence of a secure family network, Anisah, being the only birth mother from a South Asian background experienced how culture and religion played a large role in the removal of her two children. Anisah was isolated from interpersonal relationships and carried the burden of bringing shame to her community. Isolation would have been a large contributing risk factor to developing PMH issues, which Anisah discussed in the interview. Her account heavily highlighted that the South Asian community, a collectivistic community, continue to shame and reinforce stigma on mothers who conceive out of wedlock. In a BBC report by Mistry (2010), there was an underlying theme that many South Asian mothers were going to many lengths to conceal their pregnancies if they were out of wedlock. In other cases, parents would force the birth mothers to put their babies up for adoption and were considered as 'honour babies'. A transcript within the BBC report discussed that Dr Selwyn, an adoption and fostering specialist, also found that many Asian women were forced by their families to place their children up for adoption as so-called 'honour babies'. Some may argue that these forcible adoptions are still compulsory. It is difficult to know the exact statistics around this deeply rooted problem because of the concealment, but more research could go into raising

awareness around this issue to potentially prevent many more forced adoptions. Though there was only one non- White British birth mother within this sample, the case of Anisah demonstrated how the decision to keep the children out of wedlock led to a series of events that isolated her from a social network and exposed her to the risks of an abusive relationship, in turn, leading to the removal of her two children. The lack of interpersonal relationships within these birth mothers' lives was a strong risk factor around the removal severity of PMH problems.

Though the sample of this research was small, two birth mothers did highlight the issues they experienced around terminating breastfeeding. Previous literature around the topic of breastfeeding birth mothers and compulsory removals have been extremely sparse which indicates a potential gap in research to be explored. Furthermore, much research has primarily focused on the positive impact that breastfeeding can have on the mother's mood and baby's development. There have been consistent findings to show that breastfeeding, where possible, is positively correlated with a child's development, and a mother's wellbeing, and protecting her somewhat against postnatal depression (McQueen, 2009; Watkins et al, 2011; La Leche League, 2020). Anisah described both physical and emotional consequences of ending breastfeeding when her son was removed from her care. When a mother ends her breastfeeding journey, hormonal changes can increase the chances of postnatal depression, and physical symptoms such as nausea or having headaches (Nair, 2018), something which Anisah experienced. Sarah's breastfeeding journey ended abruptly due to a relapse in her drinking, and a multitude of other psychosocial disadvantages. Understandably breastmilk for a premature baby is highly ideal as it provides vital nutrients to a baby, however, there was an underlying theme across all the birth mothers experiences that they often felt side-lined and unimportant to professionals. There were opportunities for health and social care staff to intervene and provide appropriate emotional and social support to Sarah. It could be suggested that the right support at the right time would have reversed the removal process for Sarah. La Leche League (2020) have argued that breastfeeding is a legal and human right which should not be dismissed. Not breastfeeding can have serious repercussions on the child's emotional and physical development, and on the mother's emotional wellbeing. La Leche League (2020) have also advised to seek professional support for parents who may be at risk of having this right removed. They have also highlighted that some judges, and professionals within the child protection services may not be aware of the impact stopping

breastfeeding can have, and so more awareness and training should be provided. Due to a lack of literature around the topic of breastfeeding and birth mothers of compulsory removals, future research could focus on the psychological and physical trauma a birth mother experiences from the cessation of breastfeeding.

13.2c Complex grief and psychosocial crisis:

There was an overt sense that all the birth mothers were experiencing grief after the removal of their child. Grief that was very much akin to that of child loss through death. However, unlike grief from death, the loss from compulsory adoption can often be described as complex, or continuous grief, meaning life for both parties will continue- yet separately (Adoption Birth Mothers, 2016). This was true in the case of some of the birth mothers who described that the process of removing a child to adoption was that of grieving a dead child, and fits in line with existing literature where Charlton et al (1998) had interviewed birth mothers of compulsory removals with most reporting feelings similar to bereavement. But the problem lies in the lack of acknowledgment by society that these women are experiencing complex bereavement (Marsh et al, 2006). With a lack of acknowledgment by both society and professionals, it can further perpetuate feelings of guilt, feelings of failure, and reinforce stigma that birth parents face. It can also have an adverse effect on the birth mother's self-esteem and self-worth throughout their life. In turn, the unresolved grief can lead to negative coping mechanisms such as repeated pregnancies, a suppression of feelings, or engaging in dangerous health behaviours (Masson & Dickens, 2015), and this was particularly true for all birth mothers in this research. Broadhurst & Mason (2019) describe this as immediate devastation, and consequences can be long-lasting and damaging. Psychosocial crisis points such as suicidal thoughts, self-harm, drink, drugs and multiple sexual partners was consistent amongst all the birth mothers following the removal of their child, adding to their vulnerability. Broadhurst & Mason (2019) highlight that it is imperative to provide adequate support following the removal of a child where the risks of crisis points are high. As pointed out in previous literature, there is a danger that unresolved grief through losing a child to adoption, can be a great determinant for poorer attachment in subsequent children too (Charlton et al, 1998). Screening for PMH symptoms should be conducted early on during pregnancy, and regularly followed-up as this would allow for professionals to explore with

the mother what support she would require, and if needed allow the implementation of any interventions.

13.2d Subsequent children:

There were three birth mothers who went on to have subsequent children following the removal of their initial child(ren). Previous research has indicated that mothers who enter repeated pregnancies, are almost always unsuccessful in keeping their children within their care. This is usually because courts have simply not given mothers enough time to demonstrate change (Broadhurst et al, 2015). Yet, within this research those three birth mothers who did have further children, were all successful in keeping them within their care. Though the birth mothers in this research did not state their age when they went on to have subsequent children, a significant amount of time had passed in which they were given the opportunity to demonstrate change and were able to reflect on their past experiences. This also supports the findings from Broadhurst et al's (2017) report which found that 48% of mothers within the sample were caring for a child because of making marked changes within their lives with learning from experience being a critical motivating factor in their journey towards recovery, and that care proceedings reduced with age. A large factor as to why the birth mothers within this research were successful in keeping their subsequent child was down to the supportive relationships birth mother had built with certain health professionals. This was something that had been missing previously. Birth mothers' previous histories with professionals demonstrated the lack of trust, and a sense of being seen as a failure or judged around their parenting abilities. Anisah, was the only birth mother to be offered PMH counselling through a charity. With two children already removed from her care, she made drastic life changes to ensure her 3rd child would not be removed and this was through the support of a social worker. With a PMH organisation supporting her emotionally Anisah emphasised that if this support was provided prior, her children potentially would have remained within her care. Though this is just the case for Anisah, it points in the right direction around offering PMH specific support services to birth mothers who may be at risk of removal and how this can be beneficial, and supports the idea of collaborative working amongst professionals at a statutory and voluntary level. Broadhurst et al (2017) also noted that a proportion of birth mothers who made significant changes were able to build trusting relationships with professionals by being offered better help and had better access to post proceeding counselling and mental health services.

The birth mothers of this research all faced compulsory removals of their children, however, they are often disregarded in published literature further reinforcing negative connotations and stigma around their mothering abilities. The aim of this study was to explore the incidence of PMH issues within this group of women, and the psychosocial risk factors associated with it. Within this small-scaled study this research found that all birth mothers experienced PMH symptoms indicating a high prevalence and severity of the issue. These women were at potentially higher risk of developing these symptoms due to a myriad of psychosocial risk factors as outlined in the discussion. The experiences of the birth mothers within this research raises awareness around the psychosocial risk factors they may face and the importance of screening consistently for PMH issues to potentially prevent further adverse outcomes.

14.0 Implications for future research and practice:

This chapter will discuss some implications for future research. For instance, this research found that all of the birth mothers experienced severe PMH issues as a result of psychosocial risk factors. Despite these risk factors, they had limited knowledge around the signs and symptoms of PMH problems. It seems therefore crucial to screen for PMH issues in birth mothers of compulsory removals as early on as possible and regularly, to raise more awareness around PMH. Early screening can allow social workers to appropriately refer birth mothers to health professionals who can support birth parents in an emotional capacity. Often the support received by birth parents is that from the same local authority that has removed the child which can be counterproductive. Social workers could be encouraged to conduct pre-birth assessment during the first trimester of pregnancy to ensure that any signs and symptoms of PMH problems can be identified earlier on. Screening for PMH issues within the pre-birth assessment window for birth mothers of recurrent pregnancies, may allow for PMH specific support to be implemented and support a birth mothers wellbeing. This can help prevent developmental and health consequences in both mother and child. As pointed out by Broadhurst & Mason (2013) the pre-birth assessment is a crucial time for birth mothers to build trusting relationships with professionals.

Secondly, it may be beneficial for breastfeeding clinicians, midwives and health visitors working with birth mothers to be mindful around breastfeeding practices and the possibility that this may be ended abruptly during care proceedings and removals. It is well acknowledged that 'breast is best' for the child's development, but more consideration could be given to birth parents who can face early termination of breastfeeding (Le Leche League, 2020). Clinicians could be encouraged to provide tailored practical and emotional support around breastfeeding practices for birth parents facing adoption. However, the issue lies in the lack of research around breastfeeding cessation in birth mothers, which makes it a possible area of research to consider further.

Though the sample size of this research was small, the findings indicate that often pregnancies in later adulthood can successfully lead to the child remaining within birth mother's care. This may imply that maternal age had allowed the mothers to appropriately reflect on their parenting capacities, as well as allowing time to make significant positive changes. Social workers should therefore work together with young birth mothers who are at risk of repeated removals to encourage the use of contraception and education around healthier lifestyles. Previous literature has provided evidence to suggest that birth mothers of a younger age are at higher risk of recurrent removals (Broadhurst & Harwin, 2017; Broadhurst et al, 2018), and therefore later pregnancies may result in better outcomes and can help to break the cycle of adoption, and inter-generational patterns (Pause, 2020).

In recent weeks, BTC has been re-established within Birmingham Children's Trust which eradicate issues around longevity and funding. This is highly positive news as it also seeks to work closely with perinatal services. However, as this is not an independent charity or organisation, there is a chance that birth parents may not wish to engage with a service from the same local authority their child had been removed from. Still, there is benefit in providing more sustainable funding and training to 3rd sector organisations, and grass root level organisations around working with birth mothers and their perinatal mental health independent from local authority.

15.0 Methodological considerations & limitations:

This chapter will focus on the methodological considerations and limitations within this research. More specifically this section will discuss the considerations around recruiting from hard to reach populations. Furthermore, the chapter will also consider the implications of using a scale to measure historical PMH symptomology and the difficulty for mothers to focus solely on one of their pregnancies/birth experiences.

Ellard-Gray et al (2015) have argued that certain groups may be likely to be excluded from research including particular groups of women (victims of abuse) and ethnic minority communities. When populations are difficult to access, this is often known as hard to reach. They may be harder to reach because of issues such as social adversities, or because they belong to vulnerable groups that often face internal and external stigma or are discriminated against. These groups may also be hidden populations, for example, it may be difficult to access women who are abused because they may be cut off from communicating with outsiders or services, in effect, not reporting the abuse, and therefore not known to services or accessible for researchers (Ellard-Gray et al, 2015).

The sample of this research were deemed to be a vulnerable group of women who had experienced a multitude of social disadvantages. Research with vulnerable groups often seeks to address sensitive research questions which is often what can hinder participants from coming forward to take part due to revisiting distressing experiences (Tortu, Goldsamt & Hamid, 2001). In other instances, a sensitive research topic aligned with specific research questions can narrow down the pool of participants to recruit from, especially when these are already harder to reach, or hidden populations (Sydor, 2013). It was important to remember throughout recruitment and data analysis that this research aimed at capturing the experiences of historical birth mothers. Birth mother experiences of compulsory removals are rarely documented within research making this research important within the field of adoption and perinatal mental health (Memarnia, 2014). Furthermore, retrospective samples can provide an insight into addressing a specific health topic which can then be considered in future larger sample sizes. Equally, it was also important to note, that since recruitment was through an intervention program for birth mothers after the adoption process, there was a potential that birth mothers who were

currently going through care proceedings would have been disregarded within this research, and yet these women would possibly have been experiencing PMH symptoms.

It was originally proposed that the number of birth mothers to be contacted for stage 1, would be >25. This was simply because BTC had already worked with more than >25 birth mothers through a series of BTC workshops over 3 years. At a drop-in session with the BTC staff, the rationale and purpose of this research was provided to 15 women that attended. However, it became quickly apparent that recruiting these numbers would be difficult. BTC was coming to the end of its funding, and this had a knock-on effect around recruitment. With limited resources and staff shortages, BTC staff were unable to provide ongoing support to all birth mothers who had completed the program and therefore were unable to support or call-in birth mothers to complete the first stage of this study. With the BTC service coming to an end, many women were being discharged from the service during recruitment.

Those birth mothers who were initially interested in being a part of this research were either were not emotionally well enough to complete the interview, they were in full-time education or work at the time of recruitment, or simply did not feel that this research was a priority in their life whilst juggling multiple other things at once. Attrition and absenteeism are often worsened due to circumstances that are unique to a particular vulnerable group. Common participant attrition rates are affected by forgetting or deprioritising research, and often when faced with other daily stressors (Bonveski et al, 2014). This was particularly true for the BTC group who were often managing and attending multiple appointments, where this research was not a priority.

Birth mothers were asked to complete the EPDS- Lifetime (Meltzer-Brody et al, 2013) scale prior to the interviews to screen for and gain an insight into the severity of PMH symptoms. They were encouraged to focus on the worst episode of pregnancy or birth. For those women who had multiple removals or subsequent pregnancies, it was difficult to just focus on this one experience. There was therefore a possibility that the responses were a combination of pregnancy and birth related experiences. This however validated the complex identities and psychosocial circumstances of the mothers during multiple removals/ pregnancies and in many cases birth mothers often enter multiple pregnancies, births and removals (Broadhurst et al, 2011). As this was a small-scaled study, exploring

this further with a larger cohort of birth mothers would help to look more in-depth at these wider issues.

Despite the small sample size of this research, with eight birth completing stage 1, and five completing the follow up interviews and questions arising around generalisability, there is still a great benefit in researching hard to reach, hidden and vulnerable groups (Ellard-Gray et al, 2015). For instance, researchers can positively impact the wellbeing of vulnerable groups, and provide a voice and meaning for the hidden populations. The report by Welch et al (2015) also highlighted this whereby they conduced thematic analysis on four birth mothers around their experiences of post adoption. In another study, thematic analysis was used to analyse five interviews with mothers at risk of recurrent care proceedings around their relationship with their babies in an alcohol and drug court setting (Meier & Edington, 2020). Similar to the findings of this research, the small sample sizes in both papers provided preliminary findings that help to amplify voices of hidden populations, with the possibility to upscale the research (Welch et al, 2015; Meier & Edington 2020).

Secondly, Ellard-Gray et al (2015) make recommendations to network during the recruitment of this research so that agencies and services are aware of the work being carried out on vulnerable groups. This can allow for disseminating the research through representatives and or members of the community, making the result more empowering and valuable, and not just solely for academic purposes (Ellard-Gray et al, 2015). This research has been promoted across particular fields of work within the perinatal sector. The findings of this research have been requested by Birmingham Children's Trust with the aim of rolling out the BTC program UK-wide, and Acacia Family Support who seek to better support young mothers through care proceedings.

16.0 Conclusion:

This was a novel piece of research which aimed to investigate the incidence of PMH issues within birth mothers of compulsory adopted children, and the psychosocial risk factors around the development of PMH issues. Considering the implications of PMH issues within the general public, it seemed crucial to understand what psychosocial risk factors would increase the risks within birth mothers. Understanding these risk factors could assist professionals with intervening and offering support to birth mothers, and for some, this could prevent future repeated removals. Birth parents are at a higher risk of experiencing PMH problems because traditionally they are faced with a multitude of psychosocial risk factors but have often been disregarded within published literature, further perpetuating stereotypes and stigma around them. As a vulnerable, and hidden community of women, the sample of this research was small, yet provided an insight into the PMH issues and experiences amongst birth mothers of compulsory removals.

The results of this research have shown that specific PMH issues were present during pregnancy, prior to or during the removal process, and mental health deteriorated significantly after removal. Some of the more severe signs and symptoms of PMH issues included intrusive thoughts about harming oneself and unborn child, appetite and sleeping disturbances and extreme worries around baby's health. These were points in which birth mothers would have benefited greatly from professional support or intervention however were missed opportunities. At the removal point, birth mothers experienced complex grief akin to a loss of a loved one leading to a sudden or immediate devastation and a myriad of negative health or risky behaviours. With the right services or professional support in place, this may have been prevented. It can be suggested that these PMH complications were a result of a multitude of psychosocial risk factors such as a lack of professional and personal support, childhood experiences, being a victim of abuse, substance use, and being in socially disadvantageous situations which could significantly heighten the risk of PMH issues within a vulnerable group of women. Yet being marginalised can often mean these populations will often be harder to reach groups, further perpetuating PMH issues and potentially continuing the cycle of removal.

The positive results of BTC reinforces that strong professional support is key in supporting birth mothers emotionally and practically. Given that NICE (2020) recommends more focus within perinatal services to work closely with marginalised groups (), this research provides an insight into understanding the experiences of birth mothers of compulsory removals and the psychosocial risk factors of developing PMH issues. Perinatal services could be better equipped at working with birth mothers who are often discriminated against, whilst birth parent services such as BTC (recently established), could be more prepared to work alongside perinatal services. This could reduce stigma, and make birth mothers a less of a hard to reach population.

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18.0 Appendices:

Appendix A: EPDS-Lifetime Scale (Meltzer- Brody et al, 2003)

Date:
Participant no: 00

EPDS-Lifetime Scale (Meltzer-Brody et al, 2013)

Modified Lifetime Version of the Edinburgh Postnatal Depression Scale (EPDS-LIFETIME)

Section 1:

1. **How many times have you been pregnant? _____**
2. **During how many of your pregnancies did you feel sad, miserable, or very anxious? By this we mean a period of at least 2 weeks when you were not yourself and which was worse than the normal ups and downs of life? _____**
3. **After how many of your deliveries, within the first six months postpartum, did you feel sad, miserable, or very anxious? By this we mean a period of at least 2 weeks, when you were not yourself and which was worse than the normal ups and downs of life? _____**

Section 2:

Please think about the worst episode during pregnancy or after delivery.

During the worst episode of feeling sad, miserable, or very anxious during pregnancy or following delivery, how often:

	Often(3)	Sometimes(2)	Rarely(1)	Never(0)
Did you feel able to laugh or see the funny side of things?				
Were you able to look forward to things with excitement?				
Did you blame yourself unnecessarily when things went wrong?				
Were you anxious or worried for no good reason?				
Did you feel scared or panicky for no good reason?				
Did you feel overwhelmed?				
Were you so unhappy that you had difficulty sleeping?				
Did you feel sad or miserable?				
Were you so unhappy that you cried?				

Did the thought of harming yourself occur to you?				

Section 3:

Severity and Timing of Onset: During the worst episode of feeling sad, miserable, or very anxious during pregnancy or following delivery:

	YES	NO
Were the symptoms so severe that you sought professional help?		
Did the symptoms cause you problems or interfere with your day-to-day life?		
Did you require psychiatric hospitalization because of these symptoms?		

1. **Did you receive any form of treatment such as counseling or medication because of depression during pregnancy or following delivery?(tick one of the following) __ No Treatment __Counseling __Medication __Counseling and Medication**
2. **During the worst episode, when did these symptoms begin? During Pregnancy: __1st trimester __ 2nd trimester __ 3rd trimester OR After Delivery: __0–4 weeks __1–3 months __more than 3 months postpartum**
3. **During the worst episode, how long did these symptoms last? ___ Up to 2 weeks ___2–4 weeks ___1–3 months ___3–6 months ___ more than 6 months**
4. **How old were you during the worst episode? _____**

Appendix B: Initial interview schedule

General opening and closing questions	Questions/ topics relating to PND (during the period of birth and removal)	Questions relating to long-term health behaviours/ outcomes, services
• How are you feeling today? • How have you travelled? • Do you have any questions for me before we begin? • Ask them if they have heard of the term PND and what they understand by it. • Provide with definition and symptoms. • Thank you for taking part, do you have any further questions?	1) • What was your general health like before you got pregnant (mental & physical)? Previous history of mental health, health behaviours- smoking, drugs, alcohol, inactivity. • Did things change when you became pregnant? Feelings, thoughts, behaviours? • This could be positive feelings, or negative. • Was this because of their current situation? • Other psychosocial factors? • If negative feelings- did you explain your feelings to any professionals? i.e. social workers (if they were already involved). 2) • Had you heard of the term PND during your pregnancy- through Health Visitor, Social Worker, GP etc? or through family? • What did they explain to you, and how did you understand PND? • Were you given appropriate material/ information on PND? • When did children's services become involved? Pregnancy, after birth? • What were the experiences of having social workers involved? Stressful, helpful? • How did this have an impact on your wellbeing? • What sorts of things changed in terms of your thinking after you had your baby? - thoughts about motherhood, failure bonding, other stressors, loss of interests, loss of pleasure in activities etc? Mood & well-being- anxiety, panic attacks, sleeplessness, reduced appetite, aches and pains. • What were you doing as a result of all the above? • How did you cope? Support services, family, friends, avoiding support. • Had you felt like this before (if they have had previous children)?	3) • Did your feelings worsen after the adoption? What did you experience? • Coping mechanisms- health behaviours (positive or negative), social support (partner, family, friends, professionals). • Were you offered any support or information specifically around PND after the adoption? If so, what kind, or what would you have wished for? 4) • Effects on parenting other children? • Did they experience similar feelings (PND)? What was the same, what was different? • Do they feel this may have increased the risk of services being involved again? How did this make them feel? • When do you feel would have been the best time to be told about PND? • Did you have any further removals? If so, did you experience similar feelings. • Did you seek support- or not fully aware of support around PND? • What would you have liked to receive?

Appendix C: Final interview schedule

Appendix D: Ethics Approval

Amendment to Existing Research Ethics Approval

Please complete this form if you wish to make an alteration or amendment to a study that has already been scrutinised and approved by the Faculty Research Ethics Committee and forward it electronically to the Officer of FREC (researchethics@uwe.ac.uk)

UWE research ethics reference number:	*HAS.18.01.089*
Title of project:	*Exploring the possible incidence of postnatal depression in birth mothers of adopted children with experiences of compulsory adoption- a small scaled pilot study.*
Date of original approval:	*12/07/18*
Researcher:	*Puja Chandegra*
Supervisor (if applicable)	*Miles Thompson*

1. Proposed amendment: Please outline the proposed amendment to the existing approved proposal.

Following discussions with reviewers during the progression review on my professional doctorate in health psychology and taking on advice from supervisors along with my own views, I wish to make the following changes:

<u>1) Research question and aims:</u>

Revised question:

Firstly, I propose a revision to the research question and aims. Whilst the current research title reflected more of an audit or rate/frequency of PND: "*Exploring the possible incidence of postnatal depression in birth mothers of adopted children with experiences of compulsory adoption- a small scaled pilot study*", the new research question reflects more of what the literature review presents:

"*Exploring postnatal depression in birth mothers of adopted children with experiences of compulsory adoptions*"

In order to answer the new research question, there will also be a revision to the aims of this research. The original aims and objectives of the research were as followed:

1) The mothers will be asked around their general mental and physical health, health behaviours and social support before and after pregnancy. The purpose of this will help to identify if there are any common themes or factors that may have increased the incidence of the symptoms of PND.

2) The mothers will also be asked to discuss symptoms of PND in more detail and whether they received support or had heard of it during the adoption process. Although the frequency of the symptoms will already be determined from the questionnaire, the interview will allow the mothers to elaborate around the severity of their symptoms. This part of the interview will provide an insight to possible risk factors leading to the onset of PND in this group of women. Understanding risk factors are important in determining appropriate prevention or intervention measures (Andrew-Fike, 1999).

3) Will look into coping methods after the removal, and if it had any effect on their long-term health outcomes. The likelihood of reoccurring, chronic depression is higher in untreated PND (Tsivos, et al 2011), and going through a traumatic experience could increase the chances of this further. The interview will also ask if they sought any support. A lack of social and professional support may impede the recovery of PND and furthermore increase the chances of it reoccurring.

4) The interview will also look at whether they felt PND may have effected their future/ subsequent parenting (if applicable). This in turn will help to identify whether the mothers felt that PND in future parenting may have increased the risk of children's services being involved.

The new, proposed aims will be to:

1. Explore the potential incidence of PND in this population by using a screening measure (EPDS-lifetime scale).

Conduct follow up interviews with this population to:

2. Explore existing knowledge of, and personal experience of, the symptoms on PND and at what point were they present
3. Explore existing knowledge of, and personal experience of, the risk factors for PND
4. Explore if the symptoms / risk factors of PND worsened during the adoption / removal process
5. Explore if symptoms were present in subsequent pregnancies/ birth

<u>2) Revising interview questions:</u>

The second revision proposes amending the interview schedule in order to achieve fit with the revised research questions and aims. An original copy and a new, revised copy of the interview schedule is attached.

3) Threshold score for interviewing:
The third revision proposes also recruiting birth mothers for interviews who score just below the original threshold score. Originally, only those birth mothers who scored above the threshold (>12) on the EPDS-lifetime (Meltzer-Brody et al, 2003) scale would have been invited for an interview. I would now like to invite any birth mothers who score just below the cut-off scores. Justification for this is in the box below.

2. Reason for amendment. Please state the reason for the proposed amendment.

Reason for amendment 1:
The research aims will help birth mothers to discuss their knowledge around what PND is and its symptoms and risk factors, helping them to be more open about their own personal experiences. The aims will also allow the mothers to identify the onset of their symptoms and whether circumstances played a part in their PND. It will also help to identify whether symptoms of PND had a part to play within the adoption process, or if the adoption process had a part to play in their symptoms. As many birth parents go on to have more children, it would be interesting to explore whether these symptoms were present in subsequent children following the adoption of their previous children. If so, this could help health and social care professionals be more aware of specific birth mothers who are most vulnerable in developing perinatal mental health issues.

Reason for amendment 2:
In order to achieve the aims, the revised interview schedule will look at asking mothers around their understandings of symptoms and risk factors along with their experiences around these too. This may potentially be distressing for the birth mothers, however birth mothers within After Adoption are used to questions of this nature in order for them to express why they felt their child had been removed. Furthermore, it will help to highlight some of the risk factors that may have led to the removal, and consequently help health professionals be aware of the interventions to put in place for a vulnerable group. They will be under no obligation to answer if they do not feel comfortable, and BTC will provide ongoing emotional support should they need this. BTC are aware of the potential to ask this question during the interview. Revised parts of the interview schedule are highlighted. Both original and revised interview schedules are attached.

Reason for amendment 3:
Recruiting only those scoring 12 or above, may prevent obtaining valuable data from birth mothers who may only have scored just below the cut off scores, yet still experienced some symptoms of PND. Authors have advised that scores just

below the cut off scores should not be disregarded as this could potentially prevent mothers from receiving the right support. In a systematic review of 37 validation studies (McKenzie-McHarg, Shakespeare & Gray, 2008), heterogeneity between the studies showed that it was difficult to create distinct groups for further analysis and to determine an appropriate cut off score. However positive likelihood ratios suggested that the EPDS (Cox, Holden & Sagvosky, 1987) to be an effective screening tool at detecting depression and PND when using cut off scores 9/10, but it's accuracy increased when cut off scores were 12/13 (McKenzie et al, 2008). The original EPDS (Cox et al, 1987) also provides a guideline that scores ranging between 10-12 indicate the presence of symptoms which can be discomforting, and scores above 12 require further assessment as the likelihood of depression would be high. Therefore, this study will invite birth mothers who score 9 or above as the systematic review has demonstrated it to be an appropriate score to identify symptoms of PND. Furthermore, as this is a small scaled study, lower cut off scores may mean recruiting a larger sample for the interviews, and obtaining more detailed accounts.

3. Ethical issues. Please outline any ethical issues that arise from the amendment that have not already addressed in the original ethical approval. Please also state how these will be addressed.

As the revised interview schedule will look at asking mothers around their understanding of symptoms and risk factors of PND, along with their experiences around these areas too, this may potentially be distressing for the birth mothers. However, birth mothers within After Adoption are used to questions of this nature in order for them to express why they felt their child had been removed. Furthermore, it will help to highlight some of the risk factors that may have led to the removal, and consequently help health professionals be aware of the interventions to put in place for a vulnerable group. They will be under no obligation to answer if they do not feel comfortable, and this will be stated prior to the interview commencing. BTC will provide ongoing emotional support should they need this. BTC are aware of the potential to ask this question during the interview.

To be completed by supervisor/ Lead researcher:

Signature:	*Miles Thompson*
Date:	*19th December 2018*

To be completed by Research Ethics Chair:

Send out for review:	☐ *Yes* *X No*
Comments:	

Outcome:	*X Approve* ☐ *Approved subject to conditions* ☐ *Refer to Research Ethics Committee*
Date approved:	*10th January 2019*
Signature:	*Dr Julie Woodley (via e-mail)*

Guidance on notifying UREC/FREC of an amendment.
Your study was approved based on the information provided at the time of application. If the study design changes significantly, for example a new population is to be recruited, a different method of recruitment is planned, new or different methods of data collection are planned then you need to inform the REC and explain what the ethical implications might be. Significant changes in participant information sheets, consent forms should be notified to the REC for review with an explanation of the need for changes. Any other significant changes to the protocol with ethical implications should be submitted as substantial amendments to the original application. If you are unsure about whether or not notification of an amendment is necessary please consult your departmental ethics lead or Chair of FREC.

ORIGINAL INTERVIEW SCHEDULE:

General opening and closing questions	Questions/ topics relating to PND (during the period of birth and removal)	Questions relating to long-term health behaviours/ outcomes, services
• How are you feeling today? • How have you travelled? • Do you have any questions for me before we begin? • Ask them if they have heard of the term PND and what they understand by it. • Provide with definition and symptoms. • Thank you for taking part, do you have any further questions?	1) • What was your general health like before you got pregnant (mental & physical)? Previous history of mental health, health behaviours- smoking, drugs, alcohol, inactivity. • Did things change when you became pregnant? Feelings, thoughts, behaviours? • This could be positive feelings, or negative. • Was this because of their current situation? • Other psychosocial factors? • If negative feelings- did you explain your feelings to any professionals? i.e. social workers (if they were already involved). 2) • Had you heard of the term PND during your pregnancy- through Health Visitor, Social Worker, GP etc? or through family? • What did they explain to you, and how did you understand PND? • Were you given appropriate material/ information on PND?	3) • Did your feelings worsen after the adoption? What did you experience? • Coping mechanisms- health behaviours (positive or negative), social support (partner, family, friends, professionals). • Were you offered any support or information specifically around PND after the adoption? If so, what kind, or what would you have wished for? 4) • Effects on parenting other children? • Did they experience similar feelings (PND)? What was the same, what was different? • Do they feel this may have increased the risk of services being involved again? How did this make them feel? • When do you feel would have been the best time to be told about PND? • Did you have any further removals? If so, did you experience similar feelings.

	• When did children's services become involved? Pregnancy, after birth? • What were the experiences of having social workers involved? Stressful, helpful? • How did this have an impact on your wellbeing? • What sorts of things changed in terms of your thinking after you had your baby? - thoughts about motherhood, failure bonding, other stressors, loss of interests, loss of pleasure in activities etc? Mood & well-being- anxiety, panic attacks, sleeplessness, reduced appetite, aches and pains. • What were you doing as a result of all the above? • How did you cope? Support services, family, friends, avoiding support. • Had you felt like this before (if they have had previous children)?	• Did you seek support- or not fully aware of support around PND? • What would you have liked to receive?

REVISED INTERVIEW SCHEDULE:

Aim 2:

Explore existing knowledge and personal experiences around the symptoms of PND and at what point were they present:

1. What is your understanding of pre or postnatal depression? – Acacia definition: "A type of depression that can occur during pregnancy, or up to 2 years after birth. The main difference from general depression and postnatal is that a child is also involved".
2. Are you aware of some of the signs & symptoms around PND?
3. Are you aware of how many women experience pre or postnatal depression? - Go through Acacia material and NHS material.
4. Could you talk about some of the signs or symptoms that you may have experienced?
5. During what point were you experiencing these – pregnancy / after birth? Did anything change in terms of your mood?
6. How long do you think you were experiencing these symptoms for?
7. Were any symptoms more prominent than others?
8. At what point do you think your symptoms become apparent- before the adoption process or after?
9. How did you manage/ cope with your symptoms? Did you receive any support- social or professional? If yes, what kind?

Aim 3:

Explore existing knowledge and personal experiences around the risk factors of PND:

10. Are you aware of any risks factors or what could increase the chances of developing PND? Go through some of the common risk factors.
11. At the time of your symptoms, could you talk me through if you were experiencing any recent life stressors.
12. Were your child(ren) under children's services at this point or in the adoption process?
13. How were you coping with these stressors?
14. If they had a partner- What was your relation like with your partner at this time?
15. Did you have a supportive social network (family/friends)?
16. Were any other professionals involved at this time?
17. Was there anything else that you think may have had an impact on your PND?

Aim 4:

Explore if risk factors / symptoms worsened during the adoption/ removal process:

18. During the adoption/ removal process, did your symptoms worsen?
19. What/ how were you feeling?
20. Was there anyone you could speak to about this?
21. Had your situation (risk factors) worsened during the process?
22. Do you think all of this had an impact on how much you remained involved within the adoption process?

Aim 5:

Explore if symptoms were present in subsequent pregnancies/ birth:

23. When you got pregnant again, how did you feel? – happy, worried, anxious.
24. Did you feel the similar symptoms with your previous pregnancy? Were things different?
25. Were you able to receive any support- professional/ social

Appendix E&F: Information and consent form

Participant no: 00

Exploring the possible incidence of postnatal depression in birth mothers of adopted children with experiences of compulsory adoption- a small scale pilot study
INFORMATION SHEET

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Background and Aim

The purpose of this study is to explore the experiences of postnatal depression (PND) in birth mothers who have had their child(ren) compulsorily adopted. 1 in 10 women suffer from PND (NHS, 2015) however there has been very limited research on the experiences of mothers who have had their children removed to adoption.

This research will look at whether you had experienced PND, and your experiences of PND during conception up until your child was removed. The research will also focus on your health outcomes, behaviours, your experiences of the adoption process and if any support service were involved to support you. Due to limited research of PND within birth mothers, this study will have the potential to contribute towards health and social care practice, and the practice of social workers, counsellors, therapists and psychologists within the area of adoption.

There are 2 parts to this research. The 1st stage will require you completing a questionnaire to assess whether you had experienced PND or not. If your scores indicate that you have, you will then be called back to take part in stage 2. This will be an interview which will most likely last around 1 hour with the possibility to carry on for longer.

Why you have been chosen?

You have been chosen because we understand that you have previously

experienced your child(ren) compulsorily removed to adoption. This research wants to look further into whether you may have experienced PND during the time of conception to removal (assessed through stage 1), and your experiences around this and any potential future parenting (assessed through stage 2). Take time to decide whether or not you wish to participate.

Do I have to take part?

No. It is up to you whether you wish to take part or not. Your contribution is voluntary, and if you do wish to take part then I would ask you to sign on the consent section. If you decide to change your mind you can stop at any point (during both questionnaire and interview). If you decide you do not wish to continue during the interview stage, then you have the right to withdraw at any point during the interview without a reason, and up to 2 weeks after.

Information on how to withdraw:

You can contact me on Puja2.Chandegra@live.uwe.ac.uk and provide me with your participant number that has been given to you. If you do not have access to email, you may quote your participant number to the BTC staff who will email informing me that you wish to withdraw. You do not need to provide any personal details if you do not wish to.

Confidentiality and Data Protection:

Any hard-copy information with your personal details will be stored in a secure filing system at After Adoption with your participant number on the top. If for whatever reason, this needs to leave After Adoption, your personal details will either be removed or anonymised so that it cannot be recognisable and will be transported in a lockable briefcase. BTC workers may also have access to your interviews with my consent.

During the questionnaire phase, you will be given a participant number to keep. This will correspond to your details. You can use this if you wish to contact After Adoption but do not want to provide your name. During the transcription stage, I will ensure to change your name to a pseudonym and this will be used within the thesis. The interviews will be recorded on a recording device which only I will have access to, and as soon as these are transcribed into a document, I will delete the recorded version. The document with your transcript will be kept on a password protected computer and will be assigned a pseudonym.

I will also follow the After Adoption policies for safeguarding and confidentiality.

What will happen to the results of this research?

The results of this research will be used for the final thesis. There may a possibility that the results will be used in conferences and presentations for After Adoption and other organisations. If you wish to obtain a copy, you may contact me. Your details will be kept confidential.

Contact Details:

Puja Chandegra (Trainee Health Psychologist):

Puja2.Chandegra@live.uwe.ac.uk

Miles Thompson (Supervisor):

Miles2.Thompson@uwe.ac.uk

I want to thank you for taking time to read this and hope that you wish to participate in this research.

CONSENT FORM

By signing below, you agree to the follow terms and conditions:

- I agree that I understand the purpose of this research.
- I agree that I understand how I could withdraw from this research and the time frames to do so in.
- I agree that for the purpose of transcription, I will be recorded during the interview stage using a recording device. I understand that this will be

destroyed/ deleted once it has been transferred onto a password protected computer.

- I agree that all my information will be kept confidential at the highest of abilities, however BTC workers will be able to access information with the researcher's permission.
- I understand that all my personal information will be anonymised and will not be identifiable.
- I agree on what the results of this research will be used for and who it could be presented to.
- I agree to After Adoption's policies around safeguarding, risk assessments and confidentiality.

Signature …….
Has a copy been given to the participant? Yes/ No

Appendix G: Example data transcript extract

Line	Data Transcript Extract	Descriptive notes/ initial reactions
8	H: Well, I know like pre is like pregnancy and like post is after birth	• Basic understanding of PND
14-21	So, are you aware of some of the signs and symptoms around postnatal depression? H: Erm well only by what I went through. I: Yeah, you can talk me through that if you like. H: It was just like I was just crying for no reason. I: Yep H: Not wanting to do anything, not included in anything, just like feeling a bit crappy all the time.	• Her own experiences. Maybe not seen PND in other people around her. • Physical symptoms. • Crying, no motivation, feel 'crappy' • Felt inactive.
39-43	H: I'd probably say the anxiety, erm, coz I had this like feeling that I was just going to be like my real mum. I: Ok H: So I did kind of like push maybe away a bit, erm, because I just felt like I'm going to be a rubbish mum anyway so, like what's the point.	• Fear of being like own mum. • Potentially a poor relationship with mum. • Her own mum may not have been a good role model – rubbish mum. • What's the point- giving up. • Feelings of uselessness / incapable/ giving up on hope.
46-49	I: And how did that make you feel? H: I just, to be honest I just felt like I couldn't do anything for her and I just felt like well I'm going to end up like that anyway, so it was like I just kind of gave up before I had even started.	• Feelings of giving up. • Giving up before even beginning parenting. • 'End up like that' – like own mum.
52-55	I: And so at what point were you kind of experiencing these symptoms? H: I think it was probably, maybe about 7 weeks after I had given birth, because I know it wasn't the midwife, it was the health visitor that was around then.	• During the postnatal period • Health visitor was involved at this point.
61-70	I: ... And did the health visitor say anything to you or give you any information? H: She made me do this questionnaire thing and then just, told me to go to the doctors and the doctors just gave me antidepressants.	• Questionnaire- mood related potentially. • Quick fix- medication/ anti-depressants to help with the symptoms. • Wouldn't have accepted one-to-one therapy as

	I: Ok so you hadn't received any kind of one-to-one support? H: Nah. I: Would you have wanted some at that point? H: I don't think I would have I: Hmm H: Because I don't think I would have spoken about it, well not openly.	wouldn't have spoken openly about it. • Could be due to age (18), or ashamed of feelings.
77-84	I: And how long do you think you were experiencing these symptoms for? H: ... I don't know to be honest. Because I know like because of the antidepressants I felt like all they were doing were just making me a bit more alert at night, so I wasn't sleeping through the baby crying. Like I was more alert but I didn't feel any better. I: Ok, yeah I see what you mean. So, how long, or do you remember how long you may have been on the antidepressants? H: I think I was on them for a couple of months and then I didn't bother again because I just didn't feel like they were working.	• Unsure of how long she was experiencing symptoms due to taking antidepressants. • Not sleeping through crying baby. • More alert at night- does this mean less alert in the day? - This may have impacted parenting. • Required more support than medication- 'didn't feel like they were working'.
85 90-96	I: Erm, so do you think your symptoms were more prominent... H: Erm, yeah I think so yeah, because all of a sudden, well like I was ok one day and then another day I would just wake up and I just couldn't bring myself to pick up the baby, even though she was in the mosses basket crying, and then I was crying, and, I, I thought it was for no reason. And then my sister came upstairs and I hid under the blanket so she thought that I was still sleeping. She'd take the baby and fed the baby and everything and I'd just couldn't, couldn't do it.	• Emotional symptoms • Hiding away from real emotions- denial, ashamed? • Difficulty in providing for baby/ difficulty in bonding with baby. • She may have had feelings of guilt. • Felt useless or incapable and didn't know how to talk about this to anyone.

105-107	I: Hmm. Do you think that some of your symptoms might have contributed to the health visitor contacting them? H: Probably, yeah probably, but maybe she couldn't, I don't know maybe with a bit of support or something, things might have ended up differently.	• Required further interventions earlier on. • But probably accepts that she wouldn't have taken on any other kind of support.
110-112	I: So, did you have any other kind of support to help you cope through these symptoms at the time like family, social? H: Well I had my mum and my sister	• Poor relationship with mum, but still had support from mum and sister. • Not a large social or family network.
115-118	I: Was there any other health professionals involved other than your health visitor? H: No, erm, actually yeah there was. She, she put me in contact with this nursery nurse, and she used contact me once a week.	• Only HV and nursery nurse to support mum in a professional capacity.
119 124-127	I: Ok, so are you aware of some of the risk factors associated with... H: Erm, I don't know but I think for me it was just because of me being in foster care, like it probably impacted me in that way. I: So was growing up difficult, potentially? H: Yeah.	• Understands that previous history may have impacted symptoms. • Difficult upbringing- chaotic?
145-147	H: Yeah definitely the childhood and possibly the social side as well. Because obviously I only really had my mum and sister. Erm, obviously dad wasn't around.	• Felt the absence of own father. • Social situation may have been poor.
149-153	I: ... Could you go into a little bit more detail about it, if you can recall what it was like at that time being pregnant, and having your baby in that situation?	• Unexpected pregnancy. • Not prepared. • Fear of what may come based on own experiences.

	H: Well yeah, to be honest I never wanted to have kids anyway, so when I did find out I was pregnant, I was kind of, I kind of hid away.	
154-164	I: Actually, and that is one of the risk factors of developing PND, when you don't wish to have children but then you do become pregnant. Because it can sometimes throw someone off and create anxieties. H: Oh, okay. I: Do you think that kind of explains? H: Well definitely then. I: Yeah. H: But like yeah it did all change once I had her. Like all through my pregnancy I really did think some nasty things. There was points when I'd think, why don't this baby just die inside me because I really didn't want kids.	• Makes sense as to why she may have had these feelings. • Initially mum feels like it was the postnatal phase in which she felt the symptoms. • She now mentions that during pregnancy she had intrusive thoughts about the baby.
169-183	H: Yeah because it's like evil. Like even though it's in here (points to head), it's a baby and it's evil. And it's now that you would actually think about doing anything but your like why can't it just happen. I: That's probably quite an important thing you've said because that probably impacted your bonding during your pregnancy. Do you think it might have? Like, do you think there was any difficulties bonding with your unborn baby? All these things may have increased your risks of developing postnatal depression. H: I mean to be honest, even when I was pregnant, I didn't even feel her moving. I used to tell the midwife that I had because by the time I had I admitted that I hadn't, she sent me to hospital and there was no way I was going in hospital, so I used to lie at every visit. I used to be	• Wanting something bad to happen to unborn baby. • Intrusive and vivid thoughts. • Worrying and distressing thoughts about the baby. • A way of avoiding sensation of the baby- a coping mechanism to block out that she is having a baby. • Worried about what the professionals would say. • Lying to protect self.

	like "oh yeah she's moving loads", and I hadn't felt it move once. So whether that was me just blocking out the fact that the baby is actually there, I don't know.	
186-190	H: Yeah, yeah and like every time I went for appointments and scans she was fine, it was just that I weren't feeling it. Like you could literally here on the ultrasound, the sound thing, erm, you could hear the baby moving because obviously the heartbeat had like, you could hear it move, but I just wasn't feeling it.	• Psychologically blocking out the sensation of a baby. • Biologically the baby was there and healthy. • Potentially worried about own parenting.
193-194	H: Yeah, nah I think it is the first time I have spoken about it to be fair, especially the thoughts that I was having.	• Feelings of guilt. • Maybe was too young and didn't know who to talk to around the thoughts. • Ashamed or embarrassed.
198-202	H: Yeah. So I didn't actually have them that bad where I thought actually hurting either of us but, I think I just kind of wanted it to kind of just happen naturally, like to miscarry, and I don't think, I think if it would have happened, and the midwives would have told me, I don't think I would have been bothered.	• Thoughts of baby dying naturally. • Would have been easier to blame on natural causes. • Never wanted children, so wouldn't have been bothered about unborn baby dying.
203-209	I: Ok, yeah I see what you're saying. And, did you have any feelings of guilt after that point, or? H: After the thoughts? I: Hmm. H: Yeah, yeah I did and that's probably why I never spoke about it. I: Hmm, yeah. H: Because it's like am I really evil to have thought.	• Feelings of guilt. • Felt evil having these intrusive thoughts. • Felt ashamed of having these thoughts. • Maybe felt that she would be judged if she opened up to anyone.
215-220	And when, kind of, children's services got involved after that, or during that point? H: Erm, I think during I think. Well it wasn't straight away.	• Children's services got involved after birth. • Weaned off, so baby was still young.

	I: Do you remember how long after your first child it was? H: I can't remember the exact age, but I know she was, she'd already been weaned because she was already eating foods.	
223-236	H: I think it made me worse, because I thought well they're going to take her anyway so. I: It was almost like giving up. H: Yep. I: Ok and yeah that must have been really hard for you. H: Yeah...I mean yeah it was because one point because she'd been erm, she'd been vomiting, and the health visitor told my mum to take her to the hospital and social services was going to meet her there, and I didn't even go to the hospital. I: Kind of pushed you back more? H: Yeah, I didn't even go to the hospital and though oh well they're going to take her anyway so what's the point in me being there, because I don't know, I felt like the health visitor was blaming me, so I just kind of, my mum kind of just went.	• The involvement of children's services made her feel worse. • Felt more useless/ giving up. • Recalls a previous experience where her mum was called to take baby to hospital instead. Feelings of even more uselessness as a mother. • Issues with family. • Loss of own identity. Nor a daughter or a mother? • Felt like a waste of space- 'what's the point in being there'. • Undervalued and blamed for the situation.
237-239	I: Ok yeah, and did you have anyone else with you at the time apart from your mum and sister, like a partner? H: No.	• No partner involved. • Absent father.
243-244	H: I know the nursery nurse was involved for a bit but I can't remember if she was at that time.	
247-251	I: ... Like the feelings, the thoughts, the anxiety all of that kind of, do you think that worsened with them involved? H: I think by then I just gave up. I: Hmm ok.	• Lost hope and reinforced by professionals that she would fail as a mother too.

	H: I just gave up and thought what is the point.	
254-261	H: No. It took me ages to even, to even find out about contact. It was like she came out the hospital, social worker came out, asked me to sign section 20, erm, said it would only be for 6 weeks whilst I would sort myself out, and then in that process in that time, they went and go erm and interim care order. I: Oh ok, ok, and did you kind of understand what the process was? H: Nope. Nope as far as I knew 6 weeks and she'd be back with me. That's what I was told.	• Lack of communication with professionals, inconsistent information. • Feeling let down by services who should be supporting to keep baby. • Sort myself out- going through a difficult psychosocial situation?
262-266	I: So there was no other kind of social worker supporting you? H: No. I: And do you think, did you have anyone to speak to at the time, or were you kind of left to go through it yourself? H: No not really.	• No one to give guidance around the care orders. • Young at age- probably wouldn't have accepted support but would have felt reassured knowing someone is there to support or to talk through the procedure.
267-280	I: Do you think any of your situation, like social situation worsened during that process? H: Yeah, yeah because I'd literally, I wouldn't even... like I wouldn't even get dressed or anything. Literally I'd just stay in bed. If I had like contact, I'd actually get up and shower and get dressed, but the rest of the time I'd just be in bed. I: Do you think this affected you physically, like you're eating, drinking all of those sorts of things? H: Maybe eating it did yeah and sleeping I think I overslept rather than not sleeping. I: We're you still on anti-depressants at this point or had you come off by then?	• Worsened psychosocial situation. • Lack of motivation, depressed. • Sleeping a lot more often unless for contact. • Poor health behaviours and a cycle of sleeping, lack of motivation and feeling like a failed mother. • Off the anti-depressants which were making her alert at night, this could have contributed to sleeping more. • Nothing else to do- a lot of lost hope. Loss of identity. • Potential feelings of loneliness.

	H: I think I had come off then. But yeah I think I overslept than not sleeping, because I just felt like there was nothing else to do.	
284-288	H: No I don't think I had a say erm but I did do all the things that they'd ask me to do, you know, like like I'd go to all my contacts, unless, unless I was ill, but even then I'd leave it until that morning to contact them, because I'd think "I'll be ok tomorrow", but then If I was ill I'd contact them to say I can't come to contact. And that didn't happen very often.	• Controlled by services, but cooperated with services. • Loss of own decisions/ loss of identity. • Did whatever they asked her to do to demonstrate she can be a good mother. • Being 'ill' may have happened a handful of times. • Ill from poor health behaviours due to lack of motivation?
289-301	I: So like during the actual process, were you kind of informed of what was going on etc.? H: Not really, I was told it was dual tracking at first and then they told me that they switched it to adoption, so I'd have to go to court and it was going to be a 3-day, 3-days in court, and that was it really. I: Do you think erm, that the main cause of children's services getting involved was because of your symptoms? H: Not completely, but it did play a part in it. Because I think, because the health visitor was my younger foster sister's health visitor when she was a baby, so she knew the situation that I'd been fostered and everything because obviously I was a teenager then, so she knew the situation. So I think when I got pregnant then it was the same health visitor and I felt like she was just looking for an excuse.	• Switched to adoption- traumatic/ stressful time as that is a big leap to take by services. • May suggest that there had been a crisis? Chaotic circumstances? • Felt miscommunicated with services/ professionals. • Potentially a poor relationship with professionals. • Symptoms did play a part as to why services became involved- already been a looked after child, young parent, dysfunctional/ poor family relationships. Already under the eye of services. • Creating a narrative that can be accepted- health visitor was the same and therefore had a part to play in services becoming involved. • 'Looking for an excuse'- preconception of HV.
303-309	H: Because she knew that I had no idea, like I had no idea about kids (laughs) and it was a just a case of you know you feed 'em and put them to sleep because that's all I ever really saw anybody ever	• 'She knew'- felt victimised or already a target. • Poor relationship with HV. • Expectations of what motherhood may look like vs realistic responsibilities.

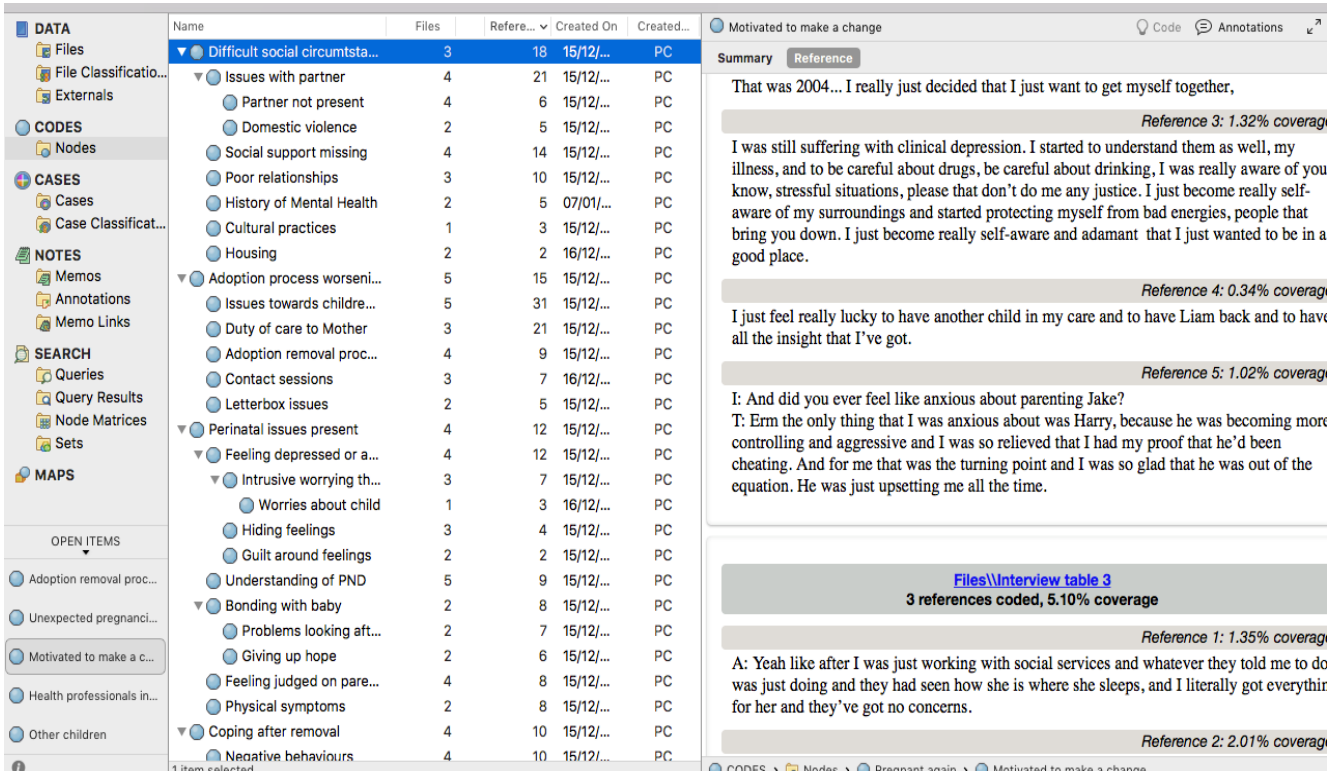
	doing, because you don't see everything else that people do, so you don't see them getting the baby into a routine, you don't see, I mean you'll see them playing but most of the time the babies are asleep. So yeah I just thought that's all it was.	• Inexperienced with children or been around children.
301-322	I: Ok yeah, and that makes sense. And then what was it like after the adoption? H: Erm... (sighs) I think I went a bit of out of control, like I just started binge drinking. I: As a coping mechanism? H: Yeah, I started binge drinking, I dabbled with certain drugs, and erm, like I was sleeping around as well. I: Do you think that was a way of just coping with whatever was going on, or was it like ok I just want to do me now? H: Erm, I don't know to be honest, because it wasn't like I would just think about it and go out drinking. But then it was hard because sometime I would be fine when I have a drink, but then other times I'd sit there and cry about the adoption and stuff.	• Hesitant. • Went out of control- engaged in negative behaviours as a coping mechanism. • Initially didn't want to have children, but when child was removed she felt the loss and trying to cope with this. • Negative psychosocial behaviours. • Despite not initially wanting children, she was hurting by the adoption. • Feelings or regret, or helplessness.
323-331	I: Yeah, and that's understandable, and how long did that go on for do you think? H: Probably about 8 years. I: So quite a while then. And did you have any other support during that period? H: I had my family and stuff, but it was hard because they were probably feeling the same emotions that you're feeling. I just felt like I couldn't talk to them. Because even though they had experienced it with their niece or granddaughter, they won't understand.	• A long period of time without any proper psychosocial support. • Her feelings and family's feelings different. A different type of loss therefore they wouldn't understand. • Saddened by outcome- blames self? • 'Couldn't talk to them', ' they won't understand' – mistrust? • Worried that she will be blamed for outcome?
335-345	I: How did you feel when you found out you were pregnant again?	• Anxieties/ worries that the same thing could happen again.

	H: Erm, it was a worry, I really had to think about what I was going to do. I didn't know whether to terminate or to carry on. I: Do you think that was because of your previous situation? H: Yep, I think the thing was more, well do I carry on with this pregnancy, and I knew social services was going to be involved anyway, I just knew. So I didn't go into it blind. Yeah I did really consider a termination, because I didn't want to be put in that situation again. I didn't want to give birth to another child and they take it. I: Do you think the level of support 10 years later was different? H: Erm, I probably did have a bit more support, not a lot.	• Termination- taking matters into own hands. • Acceptance and prepared of what may come- children's services becoming involved. • Fear of what may come. • They will take it- feelings of being controlled by services/ perception that things will be out of her hands. • Not a lot of support- low enthusiasm.
346-355	I: Were you aware, did you kind of experience the same symptoms that you did in your first pregnancy? H: No, nope. I: What was different? H: Erm, I did worry all through, because I didn't know what was going to happen, but I didn't hide away, I didn't hide away with this pregnancy. And I definitely had more motivation and that just came from a case of social services being involved. I just thought nah, I'm going to fight you and I'm keeping this one. I'm having this one and you're not taking it. I had a lot more fight in me.	• Perinatal anxiety symptoms due to previous experience. • Didn't hide away- knew she wanted to keep the baby. • Fought to keep baby- made life changes? • Older and wiser? • If a child has been previously adopted, children services will automatically be involved with subsequent children. • Internal fight- wanting to be a mum. • Motivation to change and to keep this baby/ proving people wrong.
358-364	H: I did have a midwife and because like the nurses from the previous pregnancies had told her, she did ask for my daughter's name, and I thought well I could only tell you her first name because I don't know her second name. And then I explained the situation, and she was like ok,	• Honest/ felt a fight within that she knew she was going to win. • Better professional support increasing trust and openness. • Had her say- got to tell her own version and story.

	because you've been so honest about it I do need to make a referral but I will do it with you. So did make it but atleast she did it with me and didn't just go off and do it.	
380-386	H: Erm I just think both experiences were different, and the social worker with my daughter, I think she was just tick boxing, but the 2nd one with Tom, I don't know she was a bit more people centered. Like obviously she has to tick the boxes... I: But she was taking into account your story. H: Yeah, so like I think also played a part because she was involved from when I was pregnant with my son, so...yeah consistent.	• Comparison of both experiences. • Comparison of health professionals and their styles of working having a huge impact on trustworthy and openness (people centred). • Consistent and people centred worker- understanding her story and not feeling judged.
387-409	I: Do you think that kind of helped you not experiencing PND symptoms? H: Yeah because, all through my pregnancy, I was like "am I keeping it, am I keeping it, am I keeping it?" and she never gave me an answer, even right until the very end, she wouldn't give me an answer and I found out why that was. It was because her managers wanted to go straight for an adoption, and she was like give her a chance, and she was literally fighting her managers to give me a chance. So she didn't even know what was going to happen at the end of her pregnancy. So I think she was just like I would rather just not answer than give you an answer and it turns out to be the other way. I: Did you, do you think that kind of motivated you a bit more to be like I'm fighting. H: Yeah and I think like at the end she just didn't want to stress me out. Like if it was adoption and I wasn't going to come out the hospital with my	• Continued fight to keep own baby, couldn't bare the pain of losing another child. • Was given another chance- felt valued. • A professional fighting her case- something she may have never had experienced. • Professional showing empathy. • Professionals working with birth mothers need to be supportive- going beyond their job role. • Tick box exercises should stop.

	baby, so yeah I think she did it so I wouldn't stress out. So yeah I think that plays a part. Like the kind of professionals who are involved. Because if they are just doing their job it's not going to be supportive. I: Hmm yeah. H: But yeah if they are doing their job but they are doing it because they actually care about people, it they'll be more supportive. I: And better outcomes. H: Yep.	

Appendix H: Screenshot of data coding within NVivo



Appendix I: Thematic Maps

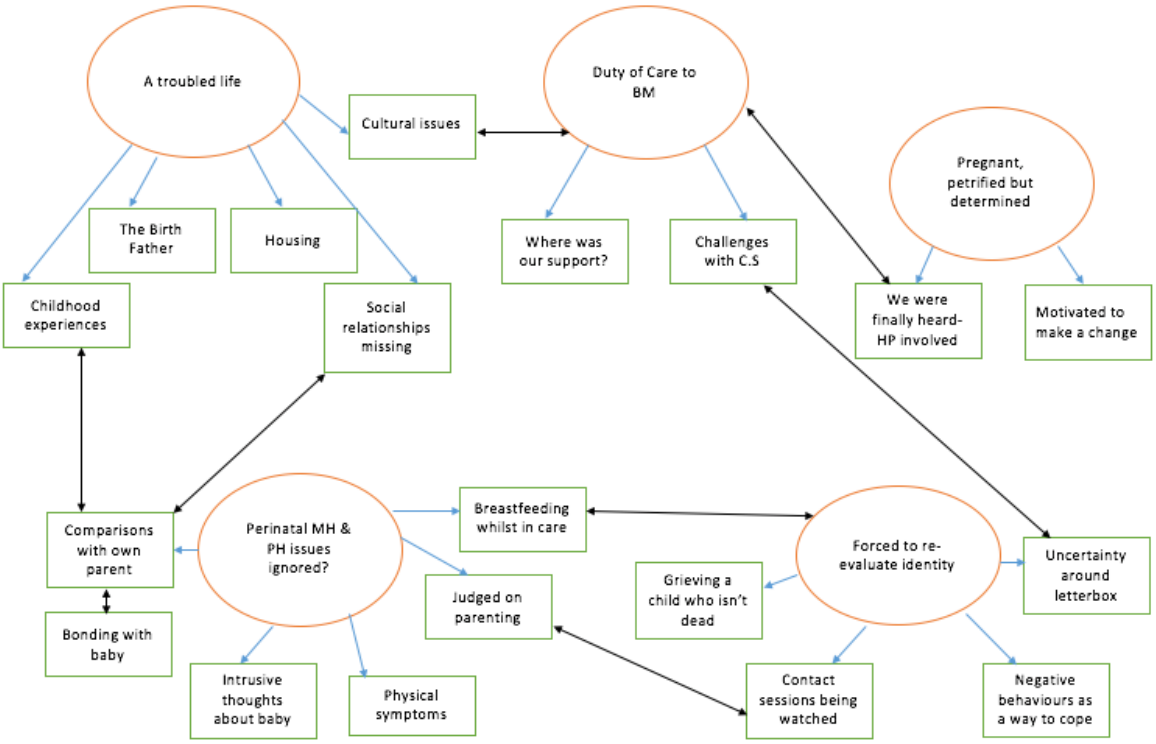


Figure 1: Initial thematic map

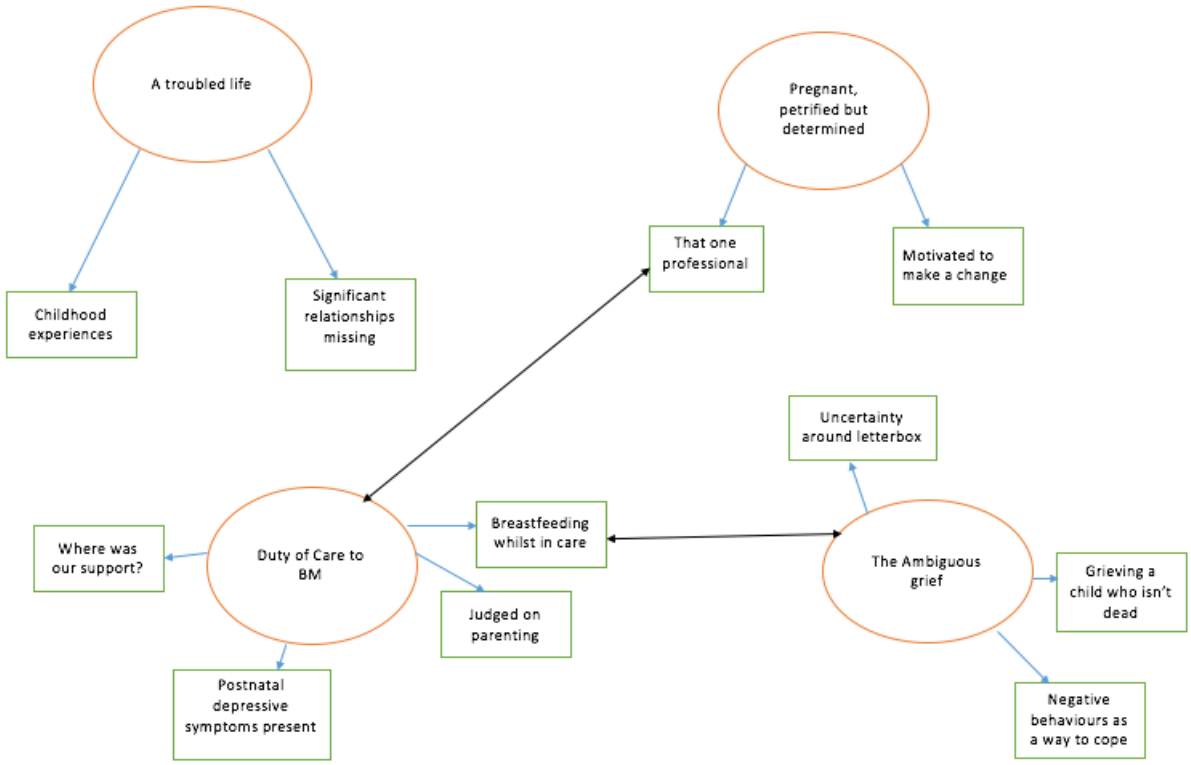


Figure 2: 2nd thematic map

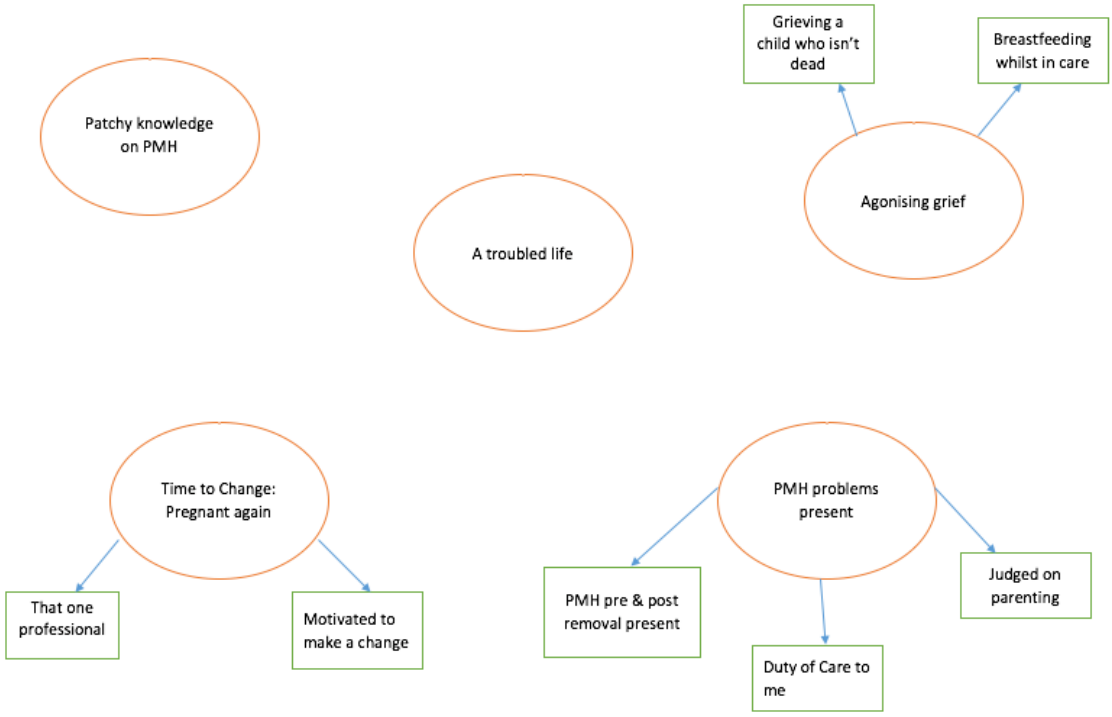


Figure 3: Final thematic map